Your summary of benefits

Anthem® Blue Cross

Effective Date: July 1, 2021

Your Plan: UC Medical Residents and Fellows - Modified Premier PPO

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Benefit Year Overall Deductible *Deductible does not cross accumulate.*	None	$100 individual / $200 family	$200 individual / $500 family
Benefit Year Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost shares during the remainder of your benefit year. UCMC and Anthem Prudent Buyer PPO Out-Of-Pocket Limit amounts cross accumulate. UCMC, Anthem Prudent Buyer PPO and Non-Network Providers Out-of-Pocket Limits do not cross accumulate.*	$1,000 single / $2,000 family	$1,000 individual/ $2,000 family	$2,000 individual / $4,000 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	No charge deductible does not apply	No charge after deductible is met
Doctor Home and Office Services			
Primary Care Visit	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care Visit	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Prenatal and Post-natal Care	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits:			
Retail Health Clinic	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Preferred On-line Visit LiveHealth Online. www.livehealthonline.com. *Includes Mental/Behavioral Health and Substance Abuse*	Not applicable	$15 copay per visit deductible does not apply	Not applicable
Manipulation Therapy *Coverage for all providers is limited to 60 visits per benefit year.*	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture *Coverage for all providers is limited to 24 visits per benefit year.*	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Other Services in an Office:			
Allergy Testing	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Allergy serum purchased separately for treatment *Billed separately from office visit.*	10% coinsurance	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Office based injectable *Prescription Drugs dispensed in the office thru infusion/ injection.*	10% coinsurance	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab:**			
Office	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:			
Office	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:			
Office	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care			
Urgent Care	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted for inpatient care*	No charge	$100 copay after deductible is met	$100 copay after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	No charge	No charge after deductible is met	No charge after deductible is met
Ambulance	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse			
Doctor Office Visit	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility visit:			
Facility Fees	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery			
Facility Fees:			
Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:			
Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):			
Facility fees (for example, room & board)	$250 per admission	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility fees if admitted as emergency	No charge	No charge deductible does not apply	No charge deductible does not apply
Doctor and other services	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation			
Home Health Care *Coverage for all providers is limited to 100 visits per benefit year. If pre-authorized, Non-Network will be paid at the Anthem Prudent Buyer PPO coinsurance level.*	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services (Including Occupational Therapy, Physical Therapy and Speech Therapy):			
Office	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation			
Office	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage for all providers is limited to 100 days per benefit year. If pre-authorized, Non-Network will be paid at the Anthem Prudent Buyer PPO coinsurance level.*	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice *If pre-authorized, Non-Network will be paid at the Anthem Prudent Buyer PPO coinsurance level.*	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment *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).*	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	Not applicable (services covered under Anthem Prudent Buyer PPO Providers)	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *National Network with R90. This plan uses a National Formulary Drug List. This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Drugs not on the list are not covered.*			
Tier 1 - Typically Generic *30 day supply (retail pharmacy).* *90 day supply (home delivery).*	$10 copay per prescription (retail and home delivery)	$10 copay per prescription (retail and home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy).* *90 day supply (home delivery).*	$20 copay per prescription (retail) and $30 copay per prescription (home delivery)	$20 copay per prescription (retail) and $30 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy).* *90 day supply (home delivery).*	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy).* *30 day supply (home delivery).*	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)

Notes:

- 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" which is generally coinsurance or coinsurance after your deductible is met.
- Member is responsible for an additional $250 copay if prior authorization is not obtained from Anthem for non-emergency admissions to Non-Network Providers.
- Anthem's maximum payment is up to $600 for non-emergency admissions to Non-Network Providers.
- Outpatient Facility tests and treatments are limited to $350 per service for Non-Network Providers. Includes Diagnostic Services, X-ray, Advanced Diagnostic Imaging, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities.

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.

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

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ□ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ□, ਤਾਂ ਅਸ□ ਇਸ ਨੂੰ ਪੜਹ੍ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ□ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਖਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through

interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.