# University of Cincinnati: CMM Indemnity Plan

**Coverage Period:** 01/01/2015 - 12/31/2015

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage for:** Individual/Family  
**Plan Type:** Indemnity

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**Important Questions** | **Answers** | **Why this Matters:**
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What is the overall deductible? | **$100** Single/**$200** Family for Network Providers. | See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an annual out-of-pocket limit on my expenses? | Yes, medical out-of-pocket is **$400** Single/**Unlimited** Family for Network Providers. | The annual out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the annual out-of-pocket limit? | Premiums, copayments, Balance-billed charges and Health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. Lifetime maximum of $500,000.

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**Questions:** Call 1-844-249-5372 or visit us at [www.anthem.com](http://www.anthem.com). If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-844-249-5372 to request a copy.
Does this plan use a network of providers? Yes. See www.anthem.com or call 1-844-249-5372 for a list of Network Providers.

If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

Do I need a referral to see a specialist? No. You don’t need a referral to see a specialist.

You can see the specialist you choose without permission from this plan.

Are there services this plan doesn’t cover? Yes.

Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 10% would be $100. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use Network providers by charging you lower deductibles, copayments and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Deductible then 20% Coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Deductible then 20% Coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit (Chiropractor)</td>
<td>Deductible then 20% Coinsurance</td>
<td>Coverage is limited to 20 visits. Acupuncture is not covered.</td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>Your Cost If You Use a Network Provider</td>
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<td>----------------------</td>
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<td>----------------------------------------</td>
<td>--------------------------</td>
</tr>
</tbody>
</table>
| Preventive care/screening/immunization (Child) | • Exam, lab and x-ray  
• Immunizations  
• HPV vaccine | No charge  
Deductible; 20% coinsurance  
Not covered | Child Immunizations: Covered through age 8. Not covered age 9 and over. Preventive child care limited to $500 maximum per year to age 1. Preventive child care limited to $150 maximum per year age 1 to age 9. Exam for adult routine care not covered. Woman limited 1 per year. Pap smears limited to 1 per year. Routine colonoscopy, proctosigmoidoscopy and sigmoidoscopy screenings not covered. |
| Preventive care/screening/immunization (Adult) | • Exam, lab and x-ray  
• Immunizations  
• Shingles vaccine (age 60 and over) | No charge  
Not covered  
Deductible/20% coinsurance | |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge | |
| Imaging (CT/PET scans, MRIs) | No Charge | |
| If you need drugs to treat your illness or condition | Tier 1 | Not covered | Prescription drugs are not covered |
| | Tier 2 | Not covered | |
| | Tier 3 | Not covered | |
| More information about [prescription drug coverage](#) is available at [www.anthem.com](http://www.anthem.com) | Tier 4 | Not covered. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | |
| | Physician/surgeon fees | No Charge | |
| If you need immediate medical attention | Emergency room services | No Charge | |
| | True Emergency  
Non-Emergency | Not covered | |
<p>| | Emergency medical transportation | Deductible then 20% coinsurance | |
| | Urgent care | No Charge | |</p>
<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>Prior authorization may be required. If not received, services may be denied.</td>
</tr>
</tbody>
</table>
|                                                          | Physician/surgeon fee                                     | No Charge                              | ---------none---------
|                                                          |                                                            |                                        |                                                              |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services               | Deductible then 20% coinsurance       | ---------none---------
|                                                          | Mental/Behavioral health inpatient services               | No Charge                              | Prior authorization may be required. If not received, services may be denied. |
|                                                          | Substance use disorder outpatient services                | Deductible then 20% coinsurance       | ---------none---------
|                                                          | Substance use disorder inpatient services                 | No Charge                              | Prior authorization may be required. If not received, services may be denied. |
| If you are pregnant                                      | Prenatal and postnatal care                               | Deductible then 20% coinsurance       | ---------none---------
|                                                          | Delivery and all inpatient services                       | No Charge                              | Prior authorization may be required. If not received, services may be denied. |
| If you need help recovering or have other special health needs | Home health care                                          | Deductible then 20% coinsurance       | ---------none---------
|                                                          | Rehabilitation services                                   | Deductible then 20% coinsurance       | Coverage is limited to 60 visits per Benefit Period combined for Physical, Speech and Occupational Therapy. |
|                                                          | Habilitation services                                     | Deductible then 20% coinsurance       | Habilitation visits count towards your Rehabilitation limit. |
|                                                          | Skilled nursing care                                      | No Charge                              | ---------none---------
|                                                          | Durable medical equipment                                 | Deductible then 20% coinsurance       | ---------none---------
|                                                          | Hospice service                                          | No Charge                              | ---------none---------
| If your child needs dental or eye care                   | Eye exam                                                 | Not Covered                            | ---------none---------
|                                                          | Glasses                                                  | Not Covered                            | ---------none---------
|                                                          | Dental check-up                                          | Not Covered                            | ---------none---------


Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Infertility
- Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.)
- Weight loss programs

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Medical vision exam
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing in the home.

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-249-5372. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Ohio Department of Insurance
50 West Town Street,
Third Floor, Suite 300
Columbus, OH 43215
800-686-1526 or 614-644-2673

Or Contact:
Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicasmos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非会员并需要中文协助，请联络您的销售代表或小组管理员。如果您已参保，则请使用您 ID 卡上的号码联络客户服务人员。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrador ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a’ tah ni’iligoo ci dooda’i, shikää adoolwoł iínizinigo t’àá dìnë k’ëjiígo, t’àá shoodi ba na’alnihí ya sidáhi bich’í naabidiílíid. Ei doo buigha daago ni ba’nija’go ho’aalágí bich’í hodíllní. Hai’dąą ini’taago eiya, t’àá shoodi dìnë ya atáh halne’ígí ni béešh bee hane’i wóltá’ bi’ki si‘niligí bi’këgho bich’í hodíllní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,740
- **Patient pays:** $800

### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

### Patient pays:

- **Deductibles:** $100
- **Copays:** $40
- **Coinsurance:** $510
- **Limits or exclusions:** $150
- **Total:** $800

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,290
- **Patient pays:** $1,110

### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

### Patient pays:

- **Deductibles:** $100
- **Copays:** $800
- **Coinsurance:** $130
- **Limits or exclusions:** $80
- **Total:** $1,110
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

☒ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

☒ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.