### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**University of Cincinnati: Active Employee PPO Medical Plan with Anthem**

**Coverage Period:** 01/01/2018 – 12/31/2018

**Coverage for:** Individual + Family | **Plan Type:** PPO

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**Prescription Drug Plan**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [https://eoc.anthem.com/eocdps/asos](https://eoc.anthem.com/eocdps/asos). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call (844) 249-5372 to request a copy.

#### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$100/individual or $200/family for In-Network Providers, $400/individual or $800/family for Out-of-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, Primary Care visit, Specialist visit, and Vision exam for In-Network Providers.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$1,100/individual or $2,200/family. All Providers. This plan has a separate Out of Pocket Maximum of $3,000 for In-Network Providers Prescription drugs. Plan maximum out-of-pocket is $7,350 individual / $14,700 family for In-Network Providers only; not applicable to Non-Network Providers.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Services deemed not medically necessary by Medical Management and/or Anthem,</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>

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OH/L/A/University of Cincinnati/ActivePPO-PPO/NA/4YYSP/NA/01-18
Penalties for non-compliance, **Premiums, balance-billing** charges, and health care this **plan** doesn't cover.

This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan’s network**. You will pay the most if you use an out-of-**network provider**, and you might receive a bill from a **provider** for the difference between the **provider’s** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an out-of-**network provider** for some services (such as lab work). Check with your **provider** before you get services.

<table>
<thead>
<tr>
<th>Will you pay less if you use a network provider?</th>
<th>Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (844) 249-5372 for a list of network providers.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you need a referral to see a specialist?</th>
<th>No. You can see the specialist you choose without a referral.</th>
</tr>
</thead>
</table>

**All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</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>$15/visit <strong>deductible</strong> does not apply</td>
<td>UC Physicians: $7.50/visit; deductible does not apply for In-Network providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$20/visit <strong>deductible</strong> does not apply</td>
<td>UC Physicians: $10.00/visit; deductible does not apply for In-Network providers.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Hearing exam (routine): Not covered for Out-of-<strong>Network Providers</strong>. You may have to pay for services that aren't preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>10% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$15/prescription (retail) and $30/prescription (home delivery)</td>
<td>30% <strong>coinsurance</strong> (retail)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically <strong>Preferred</strong>/Brand</td>
<td>$25/prescription (retail) and $50/prescription (home delivery)</td>
<td>30% <strong>coinsurance</strong> (retail)</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see **plan** or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).*
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<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a></td>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs National</td>
<td>$35/prescription (retail) and $70/prescription (home delivery)</td>
<td>30% coinsurance (retail)</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic) National</td>
<td>25% coinsurance up to a $250 maximum/prescription (retail) and 25% coinsurance up to a $250 maximum/prescription (home delivery)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center) Facility fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$75/visit deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room) Facility fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit deductible does not apply</td>
<td>Office Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient deductible does not apply $15/visit</td>
<td>Other Outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office Visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>$15/visit first 1 deductible does not apply then 10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
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<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>$15/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$20/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.**

- Abortion
- Dental care (adult)
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes.
- Bariatric surgery
- Dental Check-up
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Glasses for a child
- Long-term care

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Acupuncture
- Private-duty nursing only covered in the home.
- Chiropractic care 20 visits/benefit period.
- Routine eye care (adult)
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565.

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan’s overall deductible** $100
- **Specialist copayment** $20
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includes services like:

- **Specialist** office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- **Diagnostic tests** (ultrasounds and blood work)
- **Specialist** visit (anesthesia)

**Total Example Cost** $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$1,160**

**Managing Joe’s type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The **plan’s overall deductible** $100
- **Specialist copayment** $20
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includes services like:

- **Primary care physician** office visits (including disease education)
- **Diagnostic tests** (blood work)
- **Prescription drugs**
- **Durable medical equipment** (glucose meter)

**Total Example Cost** $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$991</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$9</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$55</td>
</tr>
</tbody>
</table>

The total Joe would pay is **$1,155**

**Mia’s Simple Fracture**

(in-network emergency room visit and follow up care)

- The **plan’s overall deductible** $100
- **Specialist copayment** $20
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includes services like:

- **Emergency room care** (including medical supplies)
- **Diagnostic test** (x-ray)
- **Durable medical equipment** (crutches)
- **Rehabilitation services** (physical therapy)

**Total Example Cost** $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$345</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$93</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$538**

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 249-5372

Amharic (አማርኛ): ያለም እወ ያተከብሩም ከስ ከጋብቑት የህግ ይህ ከዓይት, ይህን ከምሳሌ ይህ በተለያዩ ያሳስከ ወይም በስ *

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք (844) 249-5372:

Basa (Bassə Wùdù): M dyi dyi-die-dë bë béché bá céé-dë nià ke dyí ní, c mò nì dyi-beçèèn-dè bë m ke gbo-kpá-kpá kë bò kpë dé m bìdi-wùdùün bó pídyi. Bë m ke wùdù-zìn-nyò ñò gbo wùdù ke, dà (844) 249-5372.

Bengali (বাংলা): যদি এই নথিগুলোর বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও স্থায়ী অধিকার আপনার আছে। একজন পেশাদার যে কথা বলেন (844) 249-5372।

Burmese (မြန်မာ): အမြင်မြင်းစာကဗျင်းများဖြင့် အပြောင်းအဆိုး အခြေခံသော အချက်အချက်များဖြင့် ခရီး အချက်အချက်များဖြင့် အမြင်မြင်းစာကဗျင်းများဖြင့် အပြောင်းအဆိုး အခြေချ်အချက်များဖြင့် အမြင်မြင်းစာကဗျင်းများဖြင့် အပြောင်းအဆိုး အခြေချ်အချက်များဖြင့် အမြင်မြင်းစာကဗျင်းများဖြင့် အပြောင်းအဆိုး အခြေချ်အချက်များဖြင့် အမြင်မြင်းစာကဗျင်းများဖြင့် အပြောင်းအဆိုး အခြေချ်အချက်များဖြင့် အမြင်မြင်းစာကဗျင်းများဖြင့် 844) 249-5372.

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 249-5372。

Dinka (Dinka): Na nqom thieèe nê ke de yâ thoré, ke yìn nqom loŋ bë yi kuony ku wer akè bë geer yin ne thon du ke cin wëw tääu ke pîny. Te kë yin ba jâm wënë ran ye thok getyic, ke yìn col (844) 249-5372.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 249-5372.

Farsi (فارسی): در صورتی که سوالی بهرامون این سنده دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 844) 249-5372 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 249-5372.
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Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપની પ્રશ્નો હોય તો, આપની ભાષામાં મદદ અને માહહતી મેળવવાનો તમને અહિકાર છે. દુભાહષ્યા સાથે વાત કરવા માટે, કોલ કરો (844) 249-5372.

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Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 249-5372.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ānweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkwọ okwu kwuo okwu, kpọọ (844) 249-5372.

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**Lao** (ພາສາລາວ): ການການធ្វើធ្វើការសិក្សាដូចជាដៃរួចរាល់ទៅដល់អ្នក, ត្រូវការឈ្មោះទំនើបរបស់អ្នកដោយទំនើបរបស់អ្នក។ ទីក្រុងរបស់អ្នកនេះ (844) 249-5372.

**Navajo** (Diné): Dii naaltsoos biká’iigii lahgo bina’idilkidgo na bohóneédzá dóó bee ahóot’i’ t’áá ni nizaad k’ehjí bee niil hodoodih táadoo báah ilinígíí. Ata’ halne’iigii la’ bich’jí’ hadeesdzih ninizingo koji’ hodiiilnih (844) 249-5372.

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