

University of the Incarnate Word Bronze Medical Plan Grandfathered Plan

General Provisions

Benefit	All Providers and Facilities (Full RBP)
Aither Advocate Phone Number	866.776.4270
Benefit Period	(01/01 - 12/31) Calendar Year Accumulators
Deductible - Embedded Individual Family	\$1,500 \$3,000
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. Full RBP plan no separate In Network and Out of Network.	
Member Pays - payment based on the plan allowance	30% coinsurance
Total Maximum Out-of-Pocket - Embedded (includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses. Once met, there is no cost sharing for covered services for the rest of the calendar year). Individual Family	\$4,000 \$12,000
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. Full RBP plan no separate In Network and Out of Network.	

Enhanced Provider Benefits

Christus Santa Rosa Health System	No Cost Share
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Physician Office Services

Services rendered in a physicians office	Plan Provisions	Patient Responsibility
Primary Care Physician/Provider (office, home, virtual, phone)		\$25 copay per visit
Specialty Care Physician/ Provider (office, home, virtual, phone)		\$45 copay per visit
Laboratory Services		Covered under office visit copay, If no same day office visit, then \$25 copay per visit for PCP or \$45 copay per visit for Specialist to apply
Diagnostic Testing and X-Ray Services		Covered under office visit copay, If no same day office visit, then \$45 copay per visit
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)		Deductible then 30%
Injections (Physician & Medication)		Covered under office visit copay, If no same day office visit, then \$25 copay per visit for PCP or \$45 copay per visit for Specialist to apply
Contraceptive Management (Injections and devices)		Deductible then 30%
Office Surgery		Deductible then 30%
Walk-In Retail / Convenience Clinics		\$25 copay per visit
Allergy Injections		\$25 copay per visit for PCP or \$45 copay per visit for Specialist

Preventive Care

Service	Plan Provisions	Patient Responsibility
Routine Pediatric/Adolescent Physical Exams		No Cost Share
Routine Adult Physical Exams		No Cost Share
Adult, Pediatric and Adolescent Immunizations		No Cost Share
Mammograms, Annual Routine		No Cost Share
Preventive Contraceptive Counseling	Limit 2 per calendar year	No Cost Share
Routine Gynecological Exams, including a Pap Test		No Cost Share
Routine Screening Services		No Cost Share
Routine Colonoscopy		No Cost Share
Routine Eye Exam (with refraction and glaucoma testing)	Limit 1 visit every 2 calendar years	No Cost Share
Hearing Exam	Limit 1 every 2 calendar years	No Cost Share

Diagnostic Testing (Independent Laboratory & Freestanding Imaging Facility)

Service	Plan Provisions	Patient Responsibility
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Laboratory Services		\$25 copay per visit for PCP or \$45 copay per visit for Specialist to apply
Diagnostic Testing and X-Ray Services		\$45 copay per visit
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)		Deductible then 30%
Sleep Study (Freestanding Facility)		Deductible then 30%
Sleep Study (Home)		Deductible then 30%
Emergency Services		
Service	Plan Provisions	Patient Responsibility
Emergency Room (Including Facility, ER Physician, Radiologist, & Pathologist)	Copay waived if admitted	\$150 copay per visit
Urgent Care Office Visit Charge		\$50 copay per visit
Ambulance and other medically necessary transportation		Deductible then 30%
Non Emergent Air Ambulance		Not Covered
Ambulatory / Outpatient Surgery		
Service	Plan Provisions	Patient Responsibility
Surgery Facility		Deductible then 30%
Surgeon		Deductible then 30%
Assistant Surgeon	Surgical Assistant/Assistant Surgeon will be paid at 20% of the covered expense for surgery. Physician Assistant will be paid at 20% of the covered expense for surgery	Deductible then 30%
Anesthesiologist		Deductible then 30%
Pathologist/Radiologist		Deductible then 30%
Cochlear Implants		Deductible then 30%
Bariatric Surgery		Not Covered
Gender Dysphoria		Not Covered
Abortion	Only covered if the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest	Not Covered
Preadmission Testing		\$45 copay per visit
Medical Inpatient Services (Hospital, Medical Rehabilitation, Skilled Nursing Facility)		
Service	Plan Provisions	Patient Responsibility
Inpatient Facility	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Inpatient Physician	Precertification required	Deductible then 30%
Inpatient Physician Services (Including pathology & radiology services)	Precertification required	Deductible then 30%
Inpatient Surgery (Includes Surgeon, Assistant, Anesthesiologist, Radiologist, Pathologist)	Precertification required	Deductible then 30%
Inpatient Hospice Care	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following No Cost Share
Gender Dysphoria		Not Covered
Bariatric Surgery		Not Covered
Transplant Services (Designated Facility Only)	Precertification required	Deductible then 30%
Post Hospitalization Medical Rehab Facility	Limit 100 days per calendar year combined with SNF Precertification required	\$250 copay per day up to 5 days Admission day 6 and following No Cost Share
Skilled Nursing Facility	Limit 100 days per calendar year combined with Medical Rehab Precertification required	\$250 copay per day up to 5 days Admission day 6 and following No Cost Share
Medical Outpatient Hospital Services		
Service	Plan Provisions	Patient Responsibility
Outpatient Hospital Facility		Deductible then 30%
Outpatient Hospital Observation (Emergent only)		Deductible then 30%
Laboratory Services		No Cost Share
X-ray Services		\$45 copay per visit
Diagnostic Testing		Deductible then 30%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)		Deductible then 30%
Chemotherapy		Deductible then 30%
Radiation Therapy		Deductible then 30%
Infusion Therapy		Deductible then 30%
Cardiac Rehabilitation	Limit 60 visits per calendar year	Deductible then 30%
Physical, Speech, and Occupational Therapy	Limit 60 visits combined per calendar year	Deductible then 30%

Pulmonary Rehab/Respiratory Therapy	Limit 36 visits per calendar year	Deductible then 30%
Applied Behavior Analysis for Autism Spectrum Disorder		Not Covered
Autism Physical, Occupational, and Speech Therapy	Limit 100 visits per calendar year combined with Short term Rehab and SNF	Deductible then 30%
Maternity Services		
Service	Plan Provisions	Patient Responsibility
Prenatal Care - Physician Office Visits		No Cost Share
Inpatient Hospital (Mom)		\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Hospital Nursery (Newborn)		Deductible then 30%
Physician - Global Delivery		Deductible then 30%
Physician - Newborn		Deductible then 30%
Nurse Midwife		Deductible then 30%
Birth Center		Deductible then 30%
Lactation Counseling & Equipment	Limit 1 breast pump per calendar year Limit 6 counseling visits per calendar year	No Cost Share
Dependent Daughter Maternity		Deductible then 30%
*Precertification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.		
Therapy and Rehabilitation Services - Office		
Service	Plan Provisions	Patient Responsibility
Acupuncture Treatment		Not Covered
Applied Behavior Analysis for Autism Spectrum Disorder	Limit 60 visits per calendar year	Not Covered
Autism Physical, Occupational, and Speech Therapy	Limit 100 visits per calendar year combined with Short term Rehab and SNF	Deductible then 30%
Cardiac Rehabilitation	Limit 60 visits per calendar year	Deductible then 30%
Chemotherapy		Deductible then 30%
Chiropractic Care	Limit 60 visits per calendar year	\$45 copay per visit
Chiropractic X-Rays and Spinal Manipulations		Deductible then 30%
Dialysis		Deductible then 30%
Holistic or Homeopathic Medicine		Not Covered
Hyperbaric Treatment		Deductible then 30%
Infusion Therapy		Deductible then 30%
Infusion Specialty Medications		Deductible then 30%
Massage Therapy		Not Covered
Physical, Speech, and Occupational Therapy	Limit 60 visits combined per calendar year	Deductible then 30%
Pulmonary Rehab/Respiratory Therapy	Limit 36 visits per calendar year	Deductible then 30%
Radiation Therapy		Deductible then 30%
Mental Health Services		
Service	Plan Provisions	Patient Responsibility
Office Visit - Mental Health		\$25 copay per visit
Inpatient Mental Health Services (Facility)	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Inpatient Mental Health Services (Physician)	Precertification required	Deductible then 30%
Inpatient Lab, X-ray, Diagnostic Testing	Precertification required	Deductible then 30%
Outpatient Mental Health Services (Facility)		\$25 copay per visit
Outpatient Mental Health Services (Physician)		\$25 copay per visit
Mental Health Residential Treatment (Facility & Physician)	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Mental Health Partial Hospitalization (Facility & Physician)		\$25 copay per day
Substance Abuse		
Service	Plan Provisions	Patient Responsibility
Office Visit - Substance Abuse		\$25 copay per visit
Inpatient Detox (Facility)	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Inpatient Detox (Physician)	Precertification required	Deductible then 30%
Inpatient Lab, X-ray, Diagnostic Testing	Precertification required	Deductible then 30%
Outpatient Hospital Detox Services (Facility)		\$25 copay per visit
Outpatient Hospital Detox Services (Physician)		\$25 copay per visit
Inpatient Substance Abuse Rehab (Facility)	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%

Inpatient Substance Abuse Rehab (Physician)	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Outpatient Hospital Substance Abuse (Facility)		\$25 copay per visit
Outpatient Hospital Substance Abuse (Physician)		\$25 copay per visit
Substance Abuse Residential Treatment (Facility & Physician)	Precertification required	\$250 copay per day up to 5 days Admission day 6 and following Deductible then 30%
Substance Abuse Partial Hospitalization (Facility & Physician)		\$25 copay per day
Other Treatments/Services		
Service	Plan Provisions	Patient Responsibility
Assisted Fertilization Procedures		Not Covered
Biofeedback		Not Covered
Breavement Counseling (By Hospice Provider)		Deductible then 30%
Dental Services Related to Accidental Injury	Treatment must be within 3 months of injury	Deductible then 30%
Dental Oral Surgery	Only treatment or removal of malignant or benign tumors or removal of impacted wisdom teeth	Deductible then 30%
Diabetic Supplies		Pharmacy Benefit
Diabetic Self Managment Training		Deductible then 30%
Durable Medical Equipment and Prosthetics		Deductible then 30%
Genetic Counseling		Not Covered
Genetic Testing	Only covered when results are specifically required for a medical treatment decision	Not Covered
Glaucoma, Cataract Surgery and Lenses		Deductible then 30%
Hearing Aids		Not Covered
Home Health Care	Limit 120 visits per calendar year	No Cost Share
Hospice		Deductible then 30%
Infertility Diagnosis	Diagnosis and treatment of underlying cause only	Deductible then 30%
Medical Supplies		Deductible then 30%
Nutritional Counseling		Deductible then 30%
Private Duty Nursing	Limited to Inpatient only Limit 70 (8 hour shifts) per calendar year	Deductible then 30%
Prostate Exam		No Cost Share
Sexual Function (Diagnostic and Surgical if medically necessary)		Not Covered
Temporomandibular Joint Disorder (TMJ)		Deductible then 30%
Wigs (hair loss due to cancer treatment or alopecia related to a medical condition)	Limit 1 up to \$300 per lifetime	Deductible then 0%
Prescription Drugs		
Prescription Drug Deductible Individual/Family	N/A (No Pharmacy Deductible)	
Shared with Medical?	N/A (No Pharmacy Deductible)	
Prescription Drug Out of Pocket Maximum Individual	\$4,000	
Family	\$12,000	
Shared with Medical?	Yes	
	Retail – 30 Day Supply	
Preventive Medications	No Cost Share Under grandfathered plan, certain preventive medications have a copay	
Preferred Generic	\$10 copay per prescription	
Preferred Brand	\$25 copay per prescription	
Non-Preferred Brand	\$50 copay per prescription	
	Mail Order – 90 Day Supply	
Preventive Medications	No Cost Share Under grandfathered plan, certain preventive medications have a copay	
Preferred Generic	\$30 copay per prescription	
Preferred Brand	\$75 copay per prescription	
Non-Preferred Brand	\$150 copay per prescription	