

University of the Incarnate Word Silver Medical Plan Grandfathered Plan

General Provisions

Benefit	All Providers and Facilities (Full RBP)
Aither Advocate Phone Number	866.776.4270
Benefit Period	Calendar Year Accumulators (01/01 - 12/31)
Deductible - Embedded Individual Family	\$1,000 \$2,000

This Silver plan contains a Health Fund - The first \$500 in eligible claims is provided to each member at No Cost Share.

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	0% 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	\$1,000 \$2,000

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

Provider	Patient Responsibility
Christus Santa Rosa Health System	No Cost Share

Physician Office Services

Services rendered in a physicians office	Plan Provisions	Patient Responsibility
Primary Care Physician/Provider (office, home, virtual, phone)		Deductible then 0%
Specialty Care Physician/ Provider (office, home, virtual, phone)		Deductible then 0%
Laboratory Services		Deductible then 0%
Diagnostic Testing and X-Ray Services		Deductible then 0%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)		Deductible then 0%
Injections (Physician & Medication)		Deductible then 0%
Contraceptive Management (Injections and devices)		Deductible then 0%
Office Surgery		Deductible then 0%
Walk-In Retail / Convenience Clinics		Deductible then 0%
Allergy Injections		Deductible then 0%

Preventive Care

Service	Plan Provisions	Patient Responsibility
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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
Laboratory Services		Deductible then 0%
Diagnostic Testing and X-Ray Services		Deductible then 0%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)		Deductible then 0%
Sleep Study (Freestanding Facility)		Deductible then 0%
Sleep Study (Home)		Deductible then 0%
Emergency Services		
Service	Plan Provisions	Patient Responsibility
Emergency Room (Including Facility, ER Physician, Radiologist, & Pathologist)		Deductible then 0%
Urgent Care Office Visit Charge		Deductible then 0%
Ambulance and other medically necessary transportation		Deductible then 0%
Non Emergent Air Ambulance		Not Covered
Ambulatory / Outpatient Surgery		
Service	Plan Provisions	Patient Responsibility
Surgery Facility		Deductible then 0%
Surgeon		Deductible then 0%
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 0%
Anesthesiologist		Deductible then 0%
Pathologist/Radiologist		Deductible then 0%
Cochlear Implants		Deductible then 0%
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		Deductible then 0%
Medical Inpatient Services (Hospital, Medical Rehabilitation, Skilled Nursing Facility)		
Service	Plan Provisions	Patient Responsibility
Inpatient Facility	Precertification required	Deductible then 0%
Inpatient Physician	Precertification required	Deductible then 0%
Inpatient Physician Services (Including pathology & radiology services)	Precertification required	Deductible then 0%
Inpatient Surgery (Includes Surgeon, Assistant, Anesthesiologist, Radiologist, Pathologist)	Precertification required	Deductible then 0%
Inpatient Hospice Care	Precertification required	Deductible then 0%
Gender Dysphoria		Not Covered
Bariatric Surgery		Not Covered
Transplant Services (Designated Facility Only)	Precertification required	Deductible then 0%
Post Hospitalization Medical Rehab Facility	Limit 100 days per calendar year combined with SNF Precertification required	Deductible then 0%
Skilled Nursing Facility	Limit 100 days per calendar year combined with Medical Rehab Precertification required	Deductible then 0%
Medical Outpatient Hospital Services		
Service	Plan Provisions	Patient Responsibility
Outpatient Hospital Facility		Deductible then 0%
Outpatient Hospital Observation (Emergent only)		Deductible then 0%
Laboratory Services		Deductible then 0%
X-ray Services		Deductible then 0%
Diagnostic Testing		Deductible then 0%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)		Deductible then 0%
Chemotherapy		Deductible then 0%
Radiation Therapy		Deductible then 0%
Infusion Therapy		Deductible then 0%
Cardiac Rehabilitation	Limit 60 visits per calendar year	Deductible then 0%
Physical, Speech, and Occupational Therapy	Limit 60 visits combined per calendar year	Deductible then 0%
Pulmonary Rehab/Respiratory Therapy	Limit 36 visits per calendar year	Deductible then 0%
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 0%
Maternity Services		
Service	Plan Provisions	Patient Responsibility
Prenatal Care - Physician Office Visits		No Cost Share
Inpatient Hospital (Mom)		Deductible then 0%
Hospital Nursery (Newborn)		Deductible then 0%

Physician - Global Delivery		Deductible then 0%
Physician - Newborn		Deductible then 0%
Nurse Midwife		Deductible then 0%
Birth Center		Deductible then 0%
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 0%
*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		Not Covered
Autism Physical, Occupational, and Speech Therapy	Limit 100 visits per calendar year combined with Short term Rehab and SNF	Deductible then 0%
Cardiac Rehabilitation	Limit 60 visits per calendar year	Deductible then 0%
Chemotherapy		Deductible then 0%
Chiropractic Care	Limit 60 visits per calendar year	No Cost Share
Chiropractic X-Rays and Spinal Manipulations		Deductible then 0%
Dialysis		Deductible then 0%
Holistic or Homeopathic Medicine		Not Covered
Hyperbaric Treatment		Deductible then 0%
Infusion Therapy		Deductible then 0%
Infusion Specialty Medications		Deductible then 0%
Massage Therapy		Not Covered
Physical, Speech, and Occupational Therapy	Limit 60 visits combined per calendar year	Deductible then 0%
Pulmonary Rehab/Respiratory Therapy	Limit 36 visits per calendar year	Deductible then 0%
Radiation Therapy		Deductible then 0%
Mental Health Services		
Service	Plan Provisions	Patient Responsibility
Office Visit - Mental Health		Deductible then 0%
Inpatient Mental Health Services (Facility)	Precertification required	Deductible then 0%
Inpatient Mental Health Services (Physician)	Precertification required	Deductible then 0%
Inpatient Lab, X-ray, Diagnostic Testing	Precertification required	Deductible then 0%
Outpatient Mental Health Services (Facility)		Deductible then 0%
Outpatient Mental Health Services (Physician)		Deductible then 0%
Mental Health Residential Treatment (Facility & Physician)	Precertification required	Deductible then 0%
Mental Health Partial Hospitalization (Facility & Physician)		Deductible then 0%
Substance Abuse		
Service	Plan Provisions	Patient Responsibility
Office Visit - Substance Abuse		Deductible then 0%
Inpatient Detox (Facility)	Precertification required	Deductible then 0%
Inpatient Detox (Physician)	Precertification required	Deductible then 0%

Inpatient Lab, X-ray, Diagnostic Testing	Precertification required	Deductible then 0%
Outpatient Hospital Detox Services (Facility)		Deductible then 0%
Outpatient Hospital Detox Services (Physician)		Deductible then 0%
Inpatient Substance Abuse Rehab (Facility)	Precertification required	Deductible then 0%
Inpatient Substance Abuse Rehab (Physician)	Precertification required	Deductible then 0%
Outpatient Hospital Substance Abuse (Facility)		Deductible then 0%
Outpatient Hospital Substance Abuse (Physician)		Deductible then 0%
Substance Abuse Residential Treatment (Facility & Physician)	Precertification required	Deductible then 0%
Substance Abuse Partial Hospitalization (Facility & Physician)		Deductible then 0%
Other Treatments/Services		
Service	Plan Provisions	Patient Responsibility
Assisted Fertilization Procedures		Not Covered
Biofeedback		Not Covered
Breavement Counseling (By Hospice Provider)		Deductible then 0%
Dental Services Related to Accidental Injury	Treatment must be within 3 months of injury	Deductible then 0%
Dental Oral Surgery	Only treatment or removal of malignant or benign tumors or removal of impacted wisdom teeth	Deductible then 0%
Diabetic Supplies		Pharmacy Benefit
Diabetic Self Managment Training		Deductible then 0%
Durable Medical Equipment and Prosthetics		Deductible then 0%
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 0%
Hearing Aids		Not Covered
Home Health Care	Limit 120 visits per calendar year	No Cost Share
Hospice (Outpatient)		Deductible then 0%
Infertility Diagnosis	Diagnosis and treatment of underlying cause only	Deductible then 0%
Medical Supplies		Deductible then 0%
Nutritional Counseling		Deductible then 0%
Private Duty Nursing	Limited to Inpatient only Limit 70 (8 hour shifts) per calendar year	Deductible then 0%
Prostate Exam		No Cost Share
Sexual Function (Diagnostic and Surgical if medically necessary)		Not Covered
Temporomandibular Joint Disorder (TMJ)		Deductible then 0%
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 / Family	\$1,000 \$2,000	
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