Your summary of benefits

Anthem BlueCross

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Effective: January 1, 2017

Your Plan: University of California Medicare PPO

Please Note: this medical plan is a complement to your existing Medicare plan. Medicare benefits are primary and then the benefits of this plan are calculated to coordinate up to the Medicare allowable expense.

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 UC Medicare PPO Benefit Booklet. If there is a difference between this summary and the UC Medicare PPO Benefit Booklet, the UC Medicare PPO Benefit Booklet, will prevail.

Covered Medical Benefits	Your Cost
Calendar Year Deductible *Deductible applies to non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by this plan. (Medicare Deductible covered in full)*	$100 individual
Calendar Year Out-of-Pocket Limit *Out-of-Pocket Limit applies to all medical plan Member liability within Medicare allowable amount for Medicare covered services and Plan allowed amounts for non-Medicare covered services and Medicare covered services not paid by Medicare but paid by this plan. When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.*	$1,500 individual (includes deductible)
Doctor Home and Office Services	
Preventive care/screening/immunization	No charge
Primary care visit to treat an injury or illness	20% coinsurance
Specialist care visit	20% coinsurance
Prenatal and Post-natal Care	20% coinsurance
Other practitioner visits:	
Chiropractor services	20% coinsurance
Acupuncture *Coverage is limited to 24 visit limit per benefit period. These services are not covered by Medicare.*	20% coinsurance
Other services in an office:	
Allergy testing	20% coinsurance
Chemo/radiation therapy	20% coinsurance
Hemodialysis	20% coinsurance
Office based injectables *For the drugs itself dispensed in the office thru infusion/injection when covered by Medicare Part B*	20% coinsurance

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Diagnostic Services	
Lab:	
Office	20% coinsurance
Freestanding Lab	20% coinsurance
Outpatient Hospital	20% coinsurance
X-ray:	
Office	20% coinsurance
Freestanding Radiology Center	20% coinsurance
Outpatient Hospital	20% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):	
Office	20% coinsurance
Freestanding Radiology Center	20% coinsurance
Outpatient Hospital	20% coinsurance
Emergency and Urgent Care	
Emergency room facility services	20% coinsurance
Emergency room doctor and other services	20% coinsurance
Ambulance (air and ground)	20% coinsurance
Urgent Care (office setting)	20% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse	
Doctor office visit when covered by Medicare	20% coinsurance
Doctor office visit when not covered by Medicare *Deductible applies*	20% coinsurance
Facility fees	20% coinsurance

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Outpatient Surgery	
Facility fees:	
Hospital	20% coinsurance
Freestanding Surgical Center	20% coinsurance
Doctor and other services	20% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)	
Facility fees (for example, room & board) for first 60 days	No charge
Facility fees 61st through 91st day	20% coinsurance
Facility fees beyond lifetime reserve	20% coinsurance
Facility fees beyond the additional 365 days	20% coinsurance
Doctor and other services	20% coinsurance
Recovery & Rehabilitation	
Home health care	20% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):	
Office	20% coinsurance
Outpatient hospital	20% coinsurance
Habilitation services	20% coinsurance
Cardiac rehabilitation	
Office	20% coinsurance
Outpatient hospital	20% coinsurance
Skilled nursing care (in a facility)	
21st through 100th day	20% coinsurance
101st day and after	Not covered
Hospice	20% coinsurance
Durable Medical Equipment	20% coinsurance

Covered Medical Benefits	Your Cost
Prosthetic Devices	20% coinsurance
Hearing Aids *Coverage is limited to 2 hearing aids per 36 months. These services are not covered by Medicare.*	20% coinsurance

Notes:

- Only retirees enrolled in Medicare parts A & B are eligible for this plan.
- Medicare will always pay primary for Medicare covered services.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums include deductible and coinsurance.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health coverage so that the services received from all group coverage do not exceed 100% of the covered expense

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