Your summary of benefits

Anthem BlueCross

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Effective: January 1, 2020

Your Plan: University of California UC Care Plan

Your Network: UC Select and Anthem Preferred

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

Benefit Lifetime Maximum: Unlimited

A description of the prescription drug coverage is provided separately.

Covered Medical Benefits	Cost if you use a UC Select Provider	Cost if you use an Anthem Preferred Provider	Cost if you use an Out-of-Network Provider
Calendar Year Deductible *See notes section to understand how your deductible works. Deductible does not cross accumulate.*	None	$250 individual / $750 family	$500 individual / $1,500 family
Calendar Year Out-of-Pocket Limit *Combined with prescription out-of-pocket. When you meet your out-of-pocket limit, you will no longer have to pay cost shares during the remainder of the Calendar Year. UC Select and Anthem Preferred Out-of-Pocket maximum amounts cross accumulate. UC Select/ Anthem Preferred and Out-of-Network Providers Out-of-Pocket maximums do not cross accumulate. See notes section for additional information regarding your out of pocket maximum.*	$5,100 individual / $8,700 family	$6,600 individual / $13,200 family	$8,600 individual / $19,200 family
Doctor Home and Office Services			
Preventive care/screening/immunization	No charge	No charge	50% coinsurance
Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance	50% coinsurance
Specialist care visit	$20 copay per visit	20% coinsurance	50% coinsurance
Prenatal and Post-natal Care	$20 copay per visit *(initial visit only)*	20% coinsurance *(global pregnancy bill)*	50% coinsurance *(global pregnancy bill)*

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Other practitioner visits:			
Retail health clinic	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance
LiveHealth Online. (www.livehealthonline.com)	$20 copay per consult (deductible waived)		N/A
Chiropractor services *Coverage for all providers is limited to 24 visits per calendar year. Combined with acupuncture.*	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance
Acupuncture *Coverage for all providers is limited to 24 visits per calendar year. Combined with chiropractor services.*	N/A (services covered under Anthem Preferred)	20% coinsurance	20% coinsurance
Other services in an office:			
Allergy testing and treatment	$20 copay per visit	20% coinsurance	50% coinsurance
Allergy serum purchased separately for treatment *(billed separately from office visit)*	20% coinsurance	20% coinsurance	50% coinsurance
Chemo/radiation therapy	$20 copay per visit	20% coinsurance	50% coinsurance
Hemodialysis	$20 copay per visit	20% coinsurance	50% coinsurance
Office based injectable *For the drug itself dispensed in the office through infusion/injection.*	No charge	20% coinsurance	50% coinsurance
Diagnostic Services			
Lab: Note - you may incur an additional copay if separate unique professional services are performed by the same or different provider.			
Office	$20 copay	20% coinsurance	50% coinsurance
Freestanding Lab	$20 copay	20% coinsurance	50% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$20 copay	20% coinsurance	50% coinsurance

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X-ray: Note - you may incur an additional copay if separate unique professional services are performed by the same or different provider.			
Office	$20 copay per visit	20% coinsurance	50% coinsurance
Freestanding Radiology Center	$20 copay per visit	20% coinsurance	50% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$20 copay per visit	20% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):			
Office	$20 copay per visit	20% coinsurance	50% coinsurance
Freestanding Radiology Center	$20 copay per visit	20% coinsurance	50% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$20 copay per visit	20% coinsurance	50% coinsurance
Emergency and Urgent Care			
Emergency room facility services *Deductible does not apply. If admitted to the hospital then the $250 admission charge will apply.*	$200 copay	$200 copay	$200 copay
Emergency room doctor and other services	No charge	No charge	No charge
Ambulance (air and ground)	N/A (services covered under Anthem Preferred)	$200 copay per trip (deductible waived)	$200 copay per trip (deductible waived)
Urgent Care (office setting)	$20 copay per visit	$30 copay per visit (deductible waived)	50% coinsurance
Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse			

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Deductible is waived for services by Anthem Preferred Providers. An additional copay of $250 applies if you do not receive preauthorization for Out-of-Network Providers.			
Doctor office visit	Visit 1-3: No charge; Visit 4+: $20 copay per visit		50% coinsurance
Facility visit:			
Outpatient facility fees	$20 copay per visit		50% coinsurance
Inpatient facility fees	$250 per admission		50% coinsurance
Outpatient Surgery			
Facility fees:			
Hospital *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$100 per surgery	20% coinsurance	50% coinsurance
Freestanding Surgical Center *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$100 per surgery	20% coinsurance	50% coinsurance
Doctor and other services	No charge	20% coinsurance	50% coinsurance
Hospital Stay (most inpatient stays including maternity)			
Facility fees (for example, room & board) *An additional copay of $250 applies if you do not receive preauthorization for Out-of-Network Providers. Out-of-Network Providers are subject to a maximum payment of $300 per day.*	$250 per admission	20% coinsurance	50% coinsurance
Bariatric surgery *Prior authorization required, medically necessary surgery for weight loss, for morbid obesity only*	$250 per admission	20% coinsurance	Not covered
Doctor and other services	No charge	20% coinsurance	50% coinsurance
Recovery & Rehabilitation			

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Home health care *Coverage for all providers is limited to 100 visits per calendar year. (If pre-authorized, Out-of-Network may be paid at the Anthem Preferred Provider coinsurance level.)*	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):			
Office *Costs may vary by site of service.*	$20 copay per visit	20% coinsurance	50% coinsurance
Outpatient hospital *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$20 copay per visit	20% coinsurance	50% coinsurance
Habilitation services	$20 copay per visit	20% coinsurance	50% coinsurance
Cardiac rehabilitation			
Office	$20 copay per visit	20% coinsurance	50% coinsurance
Outpatient hospital *Out-of-Network Providers are subject to a maximum payment of $175 per visit.*	$20 copay per visit	20% coinsurance	50% coinsurance
Skilled nursing care (in a facility) *Coverage for all providers combined is limited to 100 day limit per calendar year. Out-of-Network Providers are subject to a maximum payment of $300 per day. (If pre-authorized, Out-of-Network may be paid at the Anthem Preferred Provider coinsurance level)*	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance
Hospice *(If pre-authorized, Out-of-Network may be paid at the Anthem Preferred Provider coinsurance level.)*	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance
Durable Medical Equipment	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance

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Hearing Aids *(limited to $2000 per every 36 months)*	N/A (services covered under Anthem Preferred)	50% coinsurance	50% coinsurance
Prosthetic Devices	N/A (services covered under Anthem Preferred)	20% coinsurance	50% coinsurance
Diabetes Care Benefits: Devices, equipment and supplies	20% coinsurance	20% coinsurance	50% coinsurance
Diabetes self-management training – office location *(if billed by your provider, you will also be responsible for the office visit copayment)*	$20 copay per visit	20% coinsurance	50% coinsurance
Travel Immunizations *Refer to your plan benefit booklet for more information on covered vaccinations and immunizations.*	No charge	No charge (deductible waived)	50% coinsurance
Infertility services Diagnosis of cause of Infertility *(Not covered - treatment of infertility, in-vitro fertilization, injectables for infertility, artificial insemination, GIFT and ZIFT)*	20% coinsurance	20% coinsurance	50% coinsurance
Family Planning Counseling and consulting *(Including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives.)*	No charge	No charge (deductible waived)	50% coinsurance
Tubal ligation *(an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility.)*	No charge	No charge (deductible waived)	50% coinsurance
Vasectomy *(an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)*	20% coinsurance	20% coinsurance	50% coinsurance
Cardiac rehabilitation Office	$20 copay per visit	20% coinsurance	50% coinsurance

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Care Outside of Plan Service Area

- Within US: Blue Cross Blue Shield Global Core — All covered services provided through a BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the Anthem Preferred level of the local Blue Plan allowable amount when you use an In-Network provider.
- Outside of US: Blue Cross Blue Shield Global Core — All covered services for emergency and non-emergency care will be eligible for reimbursement when received outside the US. Please refer to the Anthem Preferred Tier for covered services and corresponding member liability.

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Notes:

- Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. Preferred providers agree to accept Anthem Blue Cross allowable amount plus the plan's and any applicable member's payment as full payment for covered services. Out-of-Network providers can charge more than these amounts. When members use Out-of-Network providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Anthem Blue Cross allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
- 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible unless otherwise noted.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- Calendar Year Out-of-Pocket Limit for Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse services by Anthem Preferred Providers will be $5,100 individual/ $8,700 family.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- The maximum allowed charges for non-emergency surgery and services performed in an Out-of-Network Ambulatory Surgical Center or outpatient unit of an Out-of-Network hospital is subject to a maximum payment of $175 per visit. Members are responsible for the additional charges not covered by the maximum payment of $175. 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.
- Visit limits start accruing regardless if deductible is met or not.
- Transplants covered only when performed at Centers of Medical Excellence of Blue Distinction Centers.
- Bariatric surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled nursing facility day limit does not apply to mental health and substance abuse.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.

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