Your summary of benefits

Anthem BlueCross

Anthem Blue Cross Effective: January 1, 2020

Your Plan: University of California Health Savings Plan (HSP)

Your Network: Anthem Prudent Buyer PPO

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 Health Savings Plan benefit Booklet. If there is a difference between this summary and the UC Health Savings Plan benefit Booklet, the UC Health Savings Plan 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 an Anthem Prudent Buyer Provider	Cost if you use an Out-of-Network Provider
Calendar year Deductible *Combined with prescription. See notes section to understand how your deductible works. In-network deductible accumulates towards Out-of-Network deductible. Out-of-Network deductible does not accumulate towards In-network deductible. The family deductible is non-embedded meaning the cost shares of all family members apply to one shared family deductible. The individual deductible only applies to individuals enrolled under single coverage.*	$1,400 Individual / $2,800 Family	$2,550 Individual / $5,100 Family
Out-of-Pocket Limit *Combined with pharmacy. When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. In-network out of pocket accumulates towards Out-of-Network out of pocket. Out-of-Network out of pocket does not accumulate towards In-network out of pocket. The family out-of-pocket maximum is non-embedded meaning the cost shares of all family members apply to one shared family out-of-pocket maximum. The individual out-of-pocket maximum only applies to individuals enrolled under single coverage. See notes section for additional information regarding your out of pocket maximum.*	$4,000 Individual / $6,400 Family	$8,000 Individual / $16,000 Family
Doctor Home and Office Services		
Preventive care/screening/immunization	No charge	40% coinsurance
Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance
Specialist care visit	20% coinsurance	40% coinsurance
Prenatal and Post-natal Care	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer Provider	Cost if you use an Out-of-Network Provider
Other practitioner visits:		
Retail health clinic	20% coinsurance	40% coinsurance
On-line Visit *(LiveHealth Online. www.livehealthonline.com)*	20% coinsurance	N/A
Chiropractor services *Coverage for all providers is limited to 24 visits per calendar year. Combined with acupuncture.*	20% coinsurance	40% coinsurance
Acupuncture *Coverage for all providers is limited to 24 visits per calendar year. Combined with chiropractor services.*	20% coinsurance	20% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Allergy serum purchased separately for treatment *(billed separately from office visit)*	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Office based injectables *For the drug itself dispensed in the office through infusion/injection*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer Provider	Cost if you use an Out-of-Network Provider
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Emergency room facility services	20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting)	20% coinsurance	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance	40% coinsurance
Facility visit:		
Facility fees	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance
Freestanding Surgical Center *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer Provider	Cost if you use an Out-of-Network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Out-of-Network Providers are subject to a maximum payment of $360 per day except for services for mental / behavioral health, and substance abuse. If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay.*	20% coinsurance	40% coinsurance
Bariatric surgery *(Prior authorization required, medically necessary surgery for weight loss, for morbid obesity only)*	20% coinsurance	Not covered
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for all providers is limited to 100 days per calendar year. (If Out-of-Network is preauthorized it may be paid at the in network level)*	20% coinsurance	Not covered
Rehabilitation services (for example, physical/occupational therapy):		
Office *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance
Speech therapy	20% coinsurance	20% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital *Out-of-Network Providers are subject to a maximum payment of $210 per visit.*	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer Provider	Cost if you use an Out-of-Network Provider
Skilled Nursing Care *Coverage for all providers is limited to 100 day limit per calendar year. Additional $250 copay for Out-of-Network providers if prior authorization is not obtained.*		
Hospital	20% coinsurance	40% coinsurance
Freestanding SNF	20% coinsurance	20% coinsurance
Hospice *(If Out-of-Network is preauthorized it may be paid at the in network level)*	20% coinsurance	Not covered
Durable Medical Equipment	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Hearing Aids *(limited to $2000 per 36 months)*	50% coinsurance	50% coinsurance
Diabetes Care Benefits: Devices, equipment and supplies	20% coinsurance	40% coinsurance
Diabetes self-management training – office location	20% coinsurance	40% coinsurance
Family Planning. Counseling and consulting *(includes insertion of IUD, as well as injectable and implantable contraceptives for women)*	No charge	40% coinsurance
Tubal ligation *(an additional facility copayment may apply when services are rendered in a hospital)*	No charge	40% coinsurance
Vasectomy *(an additional facility copayment may apply when services are rendered in a hospital)*	20% coinsurance	40% coinsurance
Travel Immunizations		
ACA Travel immunizations	No charge	40% coinsurance
Non-ACA Travel immunizations: Japanese Encephalitis, Rabies, Typhoid, and Yellow Fever.	20% coinsurance	40% coinsurance

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 Blue Cross Prudent Buyer level of benefits 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 care will be eligible for reimbursement when received outside the US. Please refer to the Anthem Blue Cross Prudent Buyer level of benefits for covered services and corresponding member liability.

Notes:

- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, coinsurance and prescription drug.
- In network deductible and out of pocket maximum accumulate towards out of network deductible and out of pocket maximums. However, out of network deductible and out of pocket maximum do not accumulate towards In-network.
- 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.
- If your plan includes out of network benefit and you use an Out-of-Network provider, you are responsible for any difference between the covered expense and the actual Out-of-Network providers charge.
- 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.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or 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.
- 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 $210. Members are responsible for the additional charges not covered by the maximum payment of $210.

CA/L/F/PPO/LP2091/LR2067/01-16 C-