Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Anthem Blue Cross Life and Health Insurance Company:
University of California: CORE Plan

Coverage Period: 01/01/2024–12/31/2024
Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.UChealthplans.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (866) 406-1182 to request a copy.

### Important Questions | Answers | Why This Matters:
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**What is the overall deductible?** | $3,000/individual for All Providers. | 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 overall family deductible is met.

**Are there services covered before you meet your deductible?** | Yes. Preventive care for In-Network Providers. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.

**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | $6,350/individual or $12,700/family for All Providers. | 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.

**What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, expenses paid for infertility services, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

**Will you pay less if you use a network provider?** | Yes, Prudent Buyer PPO. See www.UChealthplans.com or call (866) 406-1182 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance-billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

**Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral.
**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information**
--- | --- | --- | ---
If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% coinsurance | 20% coinsurance | None
Specialist visit | 20% coinsurance | 20% coinsurance | None
Preventive care/screening/immunization | No charge | 20% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | Cost may vary by site of service.
Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | Coverage for Out-of-Network Provider is limited to $280 maximum/visit.
If you need drugs to treat your illness or condition | Tier 1 - Typically Generic | 20% coinsurance, after deductible (participating retail and mail order) | 20% coinsurance, after deductible - 30-day supply | Participating retail and mail order pharmacies cover up to a 90-day supply. Select specialty pharmacies cover up to a 30-day supply. Certain limitations may apply, including, for example: prior authorization and quantity limits. *See prescription drug section of the plan or policy.
| Tier 2 - Typically Preferred / Brand | 20% coinsurance, after deductible (participating retail and mail order) | 20% coinsurance, after deductible - 30-day supply |
| Tier 3 - Typically Non-Preferred / Brand | 20% coinsurance, after deductible (participating retail and mail order) | 20% coinsurance, after deductible - 30-day supply |
| Tier 4 - Typically Specialty (brand and generic) | 20% coinsurance, after deductible (select specialty pharmacies) | N/A |
If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | Coverage for Out-of-Network Provider is limited to $280 maximum/visit.
Physician/surgeon fees | 20% coinsurance | 20% coinsurance | None
If you need immediate medical attention | Emergency room care | 20% coinsurance | Covered as In-Network | 20% coinsurance for Emergency Room Physician Fee.
Emergency medical transportation | 20% coinsurance does not apply | Covered as In-Network |
Urgent care | 20% coinsurance | Covered as In-Network |

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* For more information about limitations and exceptions, see plan or policy document at www.UHealthplans.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td></td>
<td>Coverage for Out-of-Network Provider is limited to $480 maximum/day. If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td></td>
<td>Coverage for Out-of-Network Provider is limited to $480 maximum/day. If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td></td>
<td>Coverage for Out-of-Network Provider is limited to $480 maximum/day. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td></td>
<td>100 visits/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td></td>
<td>*See Therapy Services section</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Skilled nursing care</td>
<td></td>
<td>100 days limit/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td></td>
<td></td>
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</tbody>
</table>

* For more information about limitations and exceptions, see [plan](#) or policy document at [www.UHealthplans.com](#).
## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Eye exams for a child
- Routine eye care (adult)
- Long-term care

**What You Will Pay**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

\*See Vision Services section \n
\*See Dental Services section

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Acupuncture 24 visits/benefit period combined with chiropractic services.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Infertility treatment - 2 cycles per lifetime combined for GIFT, ZIFT and IVF (all infertility services are excluded from OOPM)
- Chiropractic care 24 visits/benefit period combined with acupuncture.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

* For more information about limitations and exceptions, see plan or policy document at [www.UHealthplans.com](http://www.UHealthplans.com).
Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan or policy document at www.UHealthplans.com.
**About these Coverage Examples:**

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: **$3,000**
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: **$12,700**

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,520</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: **$60**
- The total Peg would pay is **$5,580**

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: **$3,000**
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: **$5,600**

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td><strong>$959</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$240</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: **$55**
- The total Joe would pay is **$1,254**

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: **$3,000**
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: **$2,800**

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td><strong>$936</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$385</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: **$0**
- The total Mia would pay is **$1,321**

NOTE: This Summary of Benefit and Coverage attempts to show you how you and the plan share the cost for covered health care services. Any summary of benefits or cost sharing principals represents only a brief description of your benefits. Please read the booklet carefully to learn about provisions, benefits and exclusions. If any perceived conflict exists between this summary and the Plan terms, the Plan terms govern.

The plan would be responsible for the other costs of these EXAMPLE covered services.
By authority of the Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations for Faculty and Staff, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC’s contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California’s annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their Human Resources Office and retirees should call the UC Retirement Administration Service Center (800-888-8267).

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University’s affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, CA 94607, and for faculty to the Office of Academic Personnel and Programs, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lindje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (866) 406-1182

Amharic (አማርኛ): የስለወር ከማታገር ባሬ ስለሸመ ከማታገር ሲታፋ, ብወን ከማታገር ሲታፋ በሸመው ምስክሮት መፋክር ፇጉር ይታፋ ከማታገር ከማታገር ተስፋ ሰማማው ከማታገር ከማታገር ይታፋ ሰማማው ከማታገር ከማታገር (866) 406-1182 ያውለ። ሰማማው ከማታገር ከማታገር ከማታገር ከማታገር ከማታገር ከማታገር ከማታገር ከማታገር (866) 406-1182.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (866) 406-1182:

Chinese (中文): 如果您对本文件有任何疑问，您有权利使用您的语言免费获得协助和资讯。如需与译员通话，请致电 (866) 406-1182。

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (866) 406-1182.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (866) 406-1182.
Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (866) 406-1182.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν γεγοροφία, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (866) 406-1182.

**Gujarati (ગુજરાતી):** જો આ દસ્તાબ્દામાં આપણે કોઈપણ પ્રશ્નો કોય તો, કોઈપણ વગર આપણી ભાષામાં મદ્દત અને માહહતી મેળવવાનો તથ્મે અધિકાર છે. દુભાષય સાથે વાત કરવા માટે, કોલ કરો (866) 406-1182.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (866) 406-1182.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (866) 406-1182.

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (866) 406-1182.

**Igbo (Igbo):** O bụ ụ na i nwere ajụjụ ọ bula gbasara akwụkwọ a, i nwere ikike ịnwere enyemaka na ozi n'asụsụ ị na akwụghị ụgwọ ọ bula. Ka ị na ọkwọ okwu kwuo okwu, kpọọ (866) 406-1182.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (866) 406-1182.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (866) 406-1182.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (866) 406-1182.

**Japanese (日本語):** この文書についてなにか不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(866) 406-1182 にお電話ください。
Language Access Services:

Khmer (ភាសាខ្មែរ): ប្រ្រាជ្រូវបានសំរាប់ការចុះនូវការណោះក្នុងការសម្រេចការងាររបស់អ្នក ប្រឈមជាដើមឈ្មោះក្នុងអត្ថបទពីស្ថានភាពអនុវត្តន៍។ (866) 406-1182

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (866) 406-1182.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (866) 406-1182로 문의하십시오.

Lao (ພາສາລາວ): ធ្វើបានមិនមែនជាប្រភេទការណោះណាមួយទេ ។ ដោយម៉ូតូលសែនល្អបំផុតនីយមេីត្ត នៅពេលដែលប្រឈមបញ្ហាស្ថានភាពមានជាងម៉ែនបំផុត។ ទូទៅវាជាអំពីប្រសិនបើបង្ហាញ (866) 406-1182.

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