Anthem BlueCross

Effective: January 1, 2018

UC Medicare PPO Plan

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.

Prescription drug benefits are provided separately.

COVERED MEDICAL BENEFITS	**Your Cost**
Calendar Year Medical Deductible *Deductible applies to Medicare covered services and services not covered by Medicare but covered by this Plan. (This Plan also covers Medicare Part A and B Deductibles 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 that are covered by this Plan. When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of the calendar year. Prescription drug benefits are provided separately.*	$1,500 individual (includes deductible)
COVERED MEDICAL BENEFITS	
Doctor Home and Office Services • Preventive care/screening/immunization • Primary care visit to treat an injury or illness • Specialist care visit	 No Charge 20% 20%
Prenatal and Post-natal Care	20%
Other practitioner visits: • Chiropractor services • Acupuncture *(Coverage is limited to 24 visit limit per benefit period. These services are not covered by Medicare.)*	 20% 20%
Other services in an office: • Allergy testing and treatment • Chemo/radiation therapy • Hemodialysis • Office based injectable *(For drugs dispensed in the office thru infusion/injection when covered by Medicare Part B)*	 20% 20% 20% 20%
Diagnostic Services **Lab:** • Office • Freestanding Lab • Outpatient Hospital	 20% 20% 20%

X-ray: • Office • Freestanding Lab • Outpatient Hospital	 20% 20% 20%
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): • Office • Freestanding Lab • Outpatient Hospital	 20% 20% 20%
Emergency and Urgent Care • Emergency room facility services • Emergency room doctor and other services	 20% 20%
Ambulance (air and ground)	20%
Urgent Care (office setting)	20%
Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse **Doctor office visit when covered by Medicare** **Doctor office visit when not covered by Medicare** *(Deductible applies)* **Facility fees**	 20% 20% 20%
Outpatient Surgery **Facility fees:** • Hospital • Freestanding Surgical Center **Doctor and other services**	 20% 20% 20%
Hospital Stay *(all inpatient stays including maternity, mental/ behavioral health, and substance abuse)* • **Facility fees (for example, room & board) for first 60 days** • **Facility fees 61st through 91st day** • **Facility fees beyond lifetime reserve** • **Facility fees beyond the additional 365 days** **Doctor and other services**	 No charge 20% 20% 20% 20%
Recovery & Rehabilitation **Home health care**	 20%
Rehabilitation services (for example, physical/speech/occupational therapy): • Office • Outpatient hospital • Habitation services	 20% 20% 20%
Cardiac rehabilitation • Office • Outpatient hospital	 20% 20%
Skilled nursing care (in a facility) • 21st through 100th day • 101st day and after	 20% Not covered

Hospice	20%
Durable Medical Equipment	20%
Prosthetic Devices	20%
Hearing Aids *Coverage is limited to 2 hearing aids per 36 months. These services are not covered by Medicare.*	20%

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

Your 2018 Prescription Drug Benefit Chart
for
UC Medicare PPO
Effective January 1, 2018

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	**Closed**
Deductible	**$0**
Covered Services	**What you pay**
Part D Initial Coverage	
Below is your payment responsibility until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of $5,000.	
Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$30 copay
• Non-Preferred Brands	$45 copay
• Specialty Drugs (Generic and Brand)	$30 copay
• Diabetic Supplies – Alcohol Swabs and Gauze	$10 copay
• Diabetic Supplies – Insulin Syringes	$30 copay
• Part D Preventive Vaccines	$0 copay
Typically retail pharmacies dispense a 30-day supply of medication. Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays. If you purchase more than a 30-day supply at one of the UC Medical Center retail pharmacies or Costco, CVS, Vons/Safeway or Walgreens, you only pay the mail-order copay shown below.	

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
• Select Generics • Generics	$0 copay $20 copay
• Preferred Brands	$60 copay
• Non-Preferred Brands	$90 copay
• Specialty Drugs (Generic and Brand)	$60 copay
• Diabetic Supplies – Alcohol Swabs and Gauze • Diabetic Supplies – Insulin Syringes	$20 copay $60 copay
Part D Catastrophic Coverage Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $5,000.	
• Select Generics • Generic Drugs	$0 copay $0 copay
• Brand-Name Drugs	$0 copay
Extra Covered Drugs These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays. These drugs are covered by your Senior Rx Plus benefits.	
Cough and Cold **Vitamins and Minerals** **Lifestyle Drugs, including Erectile Dysfunction (ED)**	See Formulary for complete list of drugs covered
• Generics	You pay your Retail or Mail-Order copay
• Preferred Brands	You pay your Retail or Mail-Order copay
• Non-Preferred Brands	You pay your Retail or Mail-Order copay
Part B Diabetic Supplies	Lancets, Blood Sugar Diagnostics, Calibration Solutions and Glucometers
• Prescription	$0 copay
Part B Preventive Vaccines	Influenza, Pneumonia and Hepatitis B
• Per Vaccine	$0 copay
Extra Covered Drugs - California These are drugs that are covered on retiree drug plans issued in California.	
Contraceptive Devices	Limit 1 per year; Copay or coinsurance per Covered Device
• Prescription	$0 copay

- **Smoking Cessation Drugs:** Your plan includes coverage for smoking cessation drugs prescribed by a physician. See Formulary for a complete list of drugs covered.

- **Transgender Changes or Gender Identity Disorder Drugs:** You pay the applicable drug tier copay under retail or mail order. See Formulary for a complete list of drugs covered.

- **Vaccines:** Medicare covers some vaccines under Part B medical coverage and other vaccines under Part D drug coverage. Your UC drug plan provides coverage for both Part B and Part D vaccines at no cost when purchased at a network pharmacy. You also have coverage for vaccines administered at a physician's office, however the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your UC drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines covered by Part D. A list of Part D covered vaccines are included in your formulary. Part B covered vaccines are listed in the benefit chart.

- **Coverage for Out of Country Drugs:** Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States. Your plan provides coverage for outpatient prescription drugs when all of the following apply:

    1. You are outside the 50 United States, District of Columbia, and all U.S. Territories, other than the U.S. Virgin Islands, for less than six months,
    2. You remain a permanent resident of the United States while you are out of country,
    3. The drug is approved by the Food and Drug Administration (FDA), and
    4. The drug would be a covered drug by your plan if the drug was filled by a pharmacy located within the United States.

  When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see "How to ask us to pay you back" for detailed instructions.