

# Medical Benefits Summary: 2021

(Non-Medicare)

PLAN	HOSPITAL SERVICES					PHYSICIAN VISITS						OTHER BENEFITS						PRESCRIPTION DRUGS		BEHAVIORAL HEALTH <sup>8</sup>				
	Inpatient	Surgeon/ Assistant Surgeon	Emergency Room	Ambulance	Urgent Care	Office Visit	Hospital Visit	Preventive Physical Exam	Maternity Outpatient Care	Maternity Inpatient Care	Well Baby Care	Hospice Inpatient and Outpatient	Home Health Care	Skilled Nursing Facility	Outpatient X-Ray and Lab	Eye Exams	Chiropractor	Acupuncture	Retail (Up to 30-day supply)	Mail Order (Up to 90-day supply)	Mental Health Inpatient	Mental Health Outpatient Visits	Substance Abuse Inpatient	Substance Abuse Outpatient Visits
<b>UC Blue &amp; Gold HMO</b> (HMO)	\$250 copayment per admittance	No charge	\$125 (waived if admitted)	No charge	\$20	\$20	No charge	No charge	No charge	\$250 copayment per admittance	No charge	No charge	No charge	No charge (up to 100 days/calendar year)	No charge	\$20 (no charge if part of a preventive care exam)	\$20 (24 visit limit/calendar year combined with acupuncture)	\$20 (24 visit limit/calendar year combined with chiropractor)	Generic: \$5 <sup>7</sup> Brand: \$25 <sup>5-7</sup> Non-Formulary: \$40 <sup>7</sup>	Generic: \$10 Brand: \$50 <sup>5</sup> Non-Formulary: \$80	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment Visits 4+: \$20 (non-routine visits: \$0 copay for 4+ visits)	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment Visits 4+: \$20
<b>Kaiser—CA</b> (HMO)	\$250 copayment per admittance	No charge	\$125 (waived if admitted)	No charge	\$20	\$20	No charge	No charge	No charge	\$250 copayment per admittance	No charge	No charge	No charge (up to 100 visits/calendar year)	No charge (up to 100 days/calendar year)	No charge	No charge if part of a routine physical exam	\$15 (24 visit limit/calendar year combined with acupuncture)	\$15 (24 visit limit/calendar year combined with chiropractor)	30-day supply—Generic: \$5; Brand: \$25; 31–60 day supply—Generic: \$10; Brand: \$50; 61–100 day supply—Generic: \$15; Brand: \$75 Non-Formulary: does not apply	30-day supply—Generic: \$5; Brand: \$25; 31–100 day supply—Generic: \$10; Brand: \$50 Non-Formulary: does not apply	Kaiser: \$250 copayment per admittance Optum: \$250 copayment per admittance or course of treatment (preauthorization required)	Kaiser: \$20 for individual visit; \$10 for group visit. Optum: Visits 1–3: No copayment. Visits 4+: \$20	Kaiser: \$250 copayment per admittance or course of treatment (preauthorization required)	Kaiser: \$20 for individual visit; Optum: Visits 1–3: No copayment. Visits 4+: \$20
<b>UC Care In-Network: UC Select</b> (PPO)	\$250 copayment	No charge	Facility: \$300 copay per visit not resulting in admission, \$250 if admitted ER Physician Services: No charge	N/A (services covered under Anthem Preferred)	\$20	\$20	No charge	No charge	\$20 (initial visit only)	\$250 copayment per admittance	No charge	N/A (services covered under Anthem Preferred)	N/A (services covered under Anthem Preferred)	N/A (services covered under Anthem Preferred)	\$20	No charge if part of a routine physical exam	N/A (services covered under Anthem Preferred)	N/A (services covered under Anthem Preferred)	At participating pharmacies: Generic: \$5 <sup>7</sup> Brand Formulary: \$25 <sup>5-7</sup> Non-Formulary: \$40 <sup>7</sup> Specialty Medications: 30% (up to \$150 copayment maximum)	Generic: \$10 Brand Formulary: \$50 <sup>5</sup> Non-Formulary: \$80	\$250 copayment per admittance or course of treatment	Visits 1–3: No copayment Visits 4+: \$20	\$250 copayment per admittance or course of treatment	Visits 1–3: No copayment Visits 4+: \$20
<b>UC Care In-Network: Anthem Preferred</b> (PPO)	30%	30%	Facility: \$300 copay per visit not resulting in admission, \$250 if admitted ER Physician Services: No charge (not subject to calendar year deductible)	\$200/trip (not subject to calendar year deductible)	\$20	30%	30%	No charge (not subject to calendar year deductible)	30%	30%	No charge (not subject to calendar year deductible)	30%	30% (up to 100 visits/calendar year)	30% (up to 100 days/calendar year)	30%	No charge if part of a routine physical exam	30% (preferred providers and 24 visit limit/calendar year combined with acupuncture)	30% (preferred providers and 24 visit limit/calendar year combined with chiropractor)	At participating pharmacies: Generic: \$5 <sup>7</sup> Brand Formulary: \$25 <sup>5-7</sup> Non-Formulary: \$40 <sup>7</sup> Specialty Medications: 30% (up to \$150 copayment maximum)	Generic: \$10 Brand Formulary: \$50 <sup>5</sup> Non-Formulary: \$80	\$250 copayment per admittance or course of treatment	Visits 1–3: No copayment Visits 4+: \$20	\$250 copayment per admittance or course of treatment	Visits 1–3: No copayment Visits 4+: \$20
<b>UC Care Out-of-Network</b> (PPO)	50% (non-preferred hospitals subject to maximum payment of \$300/day)	50%	Facility: \$300 copay per visit not resulting in admission, \$250 if admitted ER Physician Services: No charge (not subject to calendar year deductible)	\$200/trip (not subject to calendar year deductible)	50%	50%	50%	50%	50%	50% (non-preferred hospitals subject to maximum payment of \$300/day)	50%	50% (non-preferred hospitals subject to maximum payment of \$300/day)	50% (up to 100 days/calendar year). If authorized, paid at Anthem Preferred tier.	50% (up to 100 days/calendar year). If authorized, paid at Anthem Preferred tier; otherwise, subject to maximum payment of \$300/day.	50%	50%	50% (up to allowed amount and 24 visit limit/calendar year combined with acupuncture)	30% (up to allowed amount and 24 visit limit/calendar year combined with chiropractor)	50% (of billed charges per prescription) <sup>5</sup>	Not covered	50% Additional \$250 copayment for failure to preauthorize	50%	50% Additional \$250 copayment for failure to preauthorize	50%
<b>UC Health Savings Plan In-Network</b> (PPO)	20%	20%	20%	20%	20% after deductible	20%	20%	No charge (not subject to calendar year deductible)	20%	20%	No charge (not subject to calendar year deductible)	20%	20% (up to 100 visits/calendar year)	20% (up to 100 days/calendar year)	20%	No charge if part of a routine physical exam, otherwise 20%	20% (24 visit limit/calendar year combined with acupuncture)	20% (24 visit limit/calendar year combined with chiropractor)	20% <sup>6,7</sup>	20% <sup>6</sup>	20%	20%	20%	20%
<b>UC Health Savings Plan Out-of-Network</b> (PPO)	40% (out-of-network hospitals subject to maximum payment of \$360/day)	40%	20%	20%	40% after deductible	40%	40%	40%	40%	40% (out-of-network hospitals subject to maximum payment of \$360/day)	40%	Not covered unless prior authorized. If authorized, in-network benefit applies.	Not covered unless prior authorized. If authorized, in-network benefit applies.	20% (up to 100 days/calendar year)	40%	40%	40% (up to allowed amount and 24 visit limit/calendar year combined with acupuncture)	20% (up to allowed amount and 24 visit limit/calendar year combined with chiropractor)	40% <sup>6</sup>	Not covered	40% \$250 for failure to preauthorize	40%	40% \$250 for failure to preauthorize	40%
<b>CORE</b> (PPO)	20% (out-of-network hospitals subject to maximum payment of \$480/day)	20%	20%	20%	20% after deductible	20%	20%	No charge (not subject to calendar year deductible)	20%	20% (out-of-network hospitals subject to maximum payment of \$480/day)	No charge (not subject to calendar year deductible)	20%	20% (up to 100 visits/calendar year) (out-of-network not covered)	20% (up to 100 days/calendar year) (out-of-network facilities subject to maximum payment of \$480/day)	20%	No charge if part of a routine physical exam, otherwise 20%	20% (24 visit limit/calendar year combined with acupuncture)	20% (24 visit limit/calendar year combined with chiropractor)	20% <sup>6,7</sup>	Preferred: 20% <sup>6</sup> Non-preferred: Not covered	20%	20%	20%	20%

**Note:** Benefits show what member pays.

**This is a summary only.** Important details—such as limitations, exclusions, exceptions, and other qualifiers—may not be included. For detailed information, call the plan or see their website for specific benefits, benefits when traveling overseas, provider information, and plan booklets.

**Service areas:** To determine if a medical plan provides service where you live, call the plan directly.

**For plan website links,** visit [ucnet.universityofcalifornia.edu/contacts/plan-contacts.html](http://ucnet.universityofcalifornia.edu/contacts/plan-contacts.html)

Anthem Blue Cross is the administrator of the UC Care, UC Health Savings and CORE plans.

Health Net is the administrator of the UC Blue & Gold HMO plan.

<sup>5</sup> When a generic drug is available and you or your physician choose the brand-name drug, you must pay the generic copay plus the difference between the cost of the brand-name drug and the generic equivalent. With prior authorization, exceptions for medical necessity can be made and you pay the brand-name copay.

<sup>6</sup> When a generic drug is available and you or your physician choose the brand-name drug, you must pay coinsurance on the cost of the generic drug plus the difference between the cost of the brand-name drug and the generic equivalent. With prior authorization, exceptions for medical necessity can be made and you pay coinsurance on the cost of the brand-name drug.

<sup>7</sup> 90-day supply available for maintenance medication at UC Medical Center and participating retail pharmacies at plan's mail order copay benefit level.

<sup>8</sup> PPO members receive behavioral health benefits through their medical plan. UC Blue & Gold HMO members receive behavioral health benefits from Managed Health Network (MHN). Kaiser members have access to the Kaiser benefit shown, in addition to the Optum in-network benefits and network of providers.

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, 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).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reasons other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent. Note: The continuation period is calculated from the earliest of these qualifying events and runs concurrently with any other UC options for continued coverage. See your Benefits Representative for more information.

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.

# Which medical plan is right for you?

2021 REFERENCE GUIDE

UNIVERSITY OF CALIFORNIA



## Employee Medical Plan Costs

UC will continue to pay the greater portion of monthly medical plan premiums in 2021, and employees will pay the balance as shown in the tables.

### Four Rate Levels Based on Salary

Four rate tables (“pay bands”) are shown here. Your pay band, and thus your premium, is based on your full-time salary rate as of Jan. 1, 2020. UC provides larger monthly employer contributions for those earning less to help keep premium costs from becoming a burden.

### Retiree Medical Plan Costs

Retirees can find their monthly premiums for the medical plans listed here online at [ucal.us/retireepremiums](http://ucal.us/retireepremiums)

#### FOR THOSE WITH FULL-TIME SALARY RATE OF \$59,000 OR LESS

PLAN	S	+ C	+A	+ S, C, A
CORE	\$0.00	\$0.00	\$0.00	\$0.00
Kaiser Permanente—California	\$24.97	\$44.95	\$54.69	\$74.64
UC Blue & Gold HMO	\$53.77	\$96.78	\$176.07	\$219.08
UC Care	\$141.74	\$255.13	\$358.26	\$471.65
UC Health Savings Plan	\$22.97	\$41.35	\$50.31	\$68.66

#### FOR THOSE WITH FULL-TIME SALARY RATE OF \$59,001–\$118,000

PLAN	S	+ C	+A	+ S, C, A
CORE	\$0.00	\$0.00	\$0.00	\$0.00
Kaiser Permanente—California	\$63.15	\$113.67	\$141.85	\$192.35
UC Blue & Gold HMO	\$91.95	\$165.50	\$263.23	\$336.79
UC Care	\$179.92	\$323.85	\$445.42	\$589.36
UC Health Savings Plan	\$61.15	\$110.07	\$137.47	\$186.37

S: Self +C: Self Plus Child(ren) +A: Self Plus Adult +S, C, A: Self Plus Adult and Child(ren)

#### FOR THOSE WITH FULL-TIME SALARY RATE OF \$118,001–\$176,000

PLAN	S	+ C	+A	+ S, C, A
CORE	\$0.00	\$0.00	\$0.00	\$0.00
Kaiser Permanente—California	\$102.33	\$184.19	\$219.96	\$301.80
UC Blue & Gold HMO	\$131.13	\$236.02	\$341.34	\$446.24
UC Care	\$219.10	\$394.37	\$523.53	\$698.81
UC Health Savings Plan	\$100.33	\$180.59	\$215.58	\$295.82

#### FOR THOSE WITH FULL-TIME SALARY RATE GREATER THAN \$176,000

PLAN	S	+ C	+A	+ S, C, A
CORE	\$0.00	\$0.00	\$0.00	\$0.00
Kaiser Permanente—California	\$142.90	\$257.22	\$300.89	\$415.18
UC Blue & Gold HMO	\$171.70	\$309.05	\$422.27	\$559.62
UC Care	\$259.67	\$467.40	\$604.46	\$812.19
UC Health Savings Plan	\$140.90	\$253.62	\$296.51	\$409.20

S: Self +C: Self Plus Child(ren) +A: Self Plus Adult +S, C, A: Self Plus Adult and Child(ren)

### DEFINITIONS

#### CALENDAR YEAR DEDUCTIBLE

The amount you must pay for medical services before the plan will provide benefits.

#### ANNUAL OUT-OF-POCKET MAXIMUM

The amount you must pay during the calendar year before the plan will pay 100% of covered charges. Some expenses do not apply toward the maximum; see the plan's evidence of coverage booklet.

#### COPAYMENTS

Shown in dollars; represents the amount you pay.

#### COINSURANCE

Shown as a percentage; represents the percentage of the allowable amount you pay.

#### ALLOWABLE AMOUNT

The dollar amount considered payment-in-full for services provided by the health plan carrier's network of healthcare providers. (Out-of-network providers may bill members for amounts in excess of the allowable amount.)

<sup>1</sup> UC Care deductible and out-of-pocket maximums do not cross-accumulate for in-network and out-of-network services. The UC Select and Anthem Preferred out-of-pocket maximum do cross-accumulate.

<sup>2</sup> In-network expenses count toward meeting the out-of-network deductible, but out-of-network expenses do not count toward meeting the in-network deductible (except for authorized ambulance and emergency medical services).

<sup>3</sup> This assumes you are covered Jan. 1, 2021. If you enroll later in the year, the UC contribution is prorated.

<sup>4</sup> The annual out-of-pocket maximum combines medical, behavioral health and prescription drugs.

## Medical Benefits Summary: 2021

(Non-Medicare)

PLAN	COSTS		
	Calendar Year Deductible	Health Savings Account (HSA) (UC Contribution)	Annual Out-of-Pocket Maximum <sup>4</sup>
UC Blue & Gold HMO (HMO) 1-800-539-4072	\$0	Not applicable	Individual: \$1,000 Family (3 persons or more): \$3,000
Kaiser—CA (HMO) 1-800-464-4000	\$0	Not applicable	Individual: \$1,500 Family (2 persons or more): \$3,000
UC Care In-Network: UC Select (PPO) 1-844-437-0486	\$0	Not applicable	Individual: \$6,100 <sup>1</sup> Family: \$9,700 <sup>1</sup>
UC Care In-Network: Anthem Preferred (PPO) 1-844-437-0486	Individual: \$500 <sup>1</sup> Family: \$1,000 <sup>1</sup>	Not applicable	Individual: \$7,600 <sup>1</sup> Family: \$14,200 <sup>1</sup>
UC Care Out-of-Network (PPO) 1-844-437-0486	Individual: \$750 <sup>1</sup> Family: \$1,750 <sup>1</sup>	Not applicable	Individual: \$9,600 <sup>1</sup> Family: \$20,200 <sup>1</sup>
UC Health Savings Plan In-Network (PPO) 1-844-437-0486	Individual Coverage: \$1,400 <sup>2</sup> Family Coverage: \$2,800 <sup>2</sup> (You may use your HSA funds to pay for your deductible and other eligible out-of-pocket expenses.)	Employee: up to \$500 <sup>3</sup> Employee & Adult: up to \$1,000 <sup>3</sup> Employee & Children: up to \$1,000 <sup>3</sup> Family: up to \$1,000 <sup>3</sup>	Individual Coverage: \$4,000 Family Coverage: \$6,400
UC Health Savings Plan Out-of-Network (PPO) 1-844-437-0486	Individual Coverage: \$2,550 <sup>2</sup> Family Coverage: \$5,100 <sup>2</sup> (You may use your HSA funds to pay for your deductible and other eligible out-of-pocket expenses.)	Employee: up to \$500 <sup>3</sup> Employee & Adult: up to \$1,000 <sup>3</sup> Employee & Children: up to \$1,000 <sup>3</sup> Family: up to \$1,000 <sup>3</sup>	Individual Coverage: \$8,000 Family Coverage: \$16,000
CORE (PPO) 1-844-437-0486	Individual: \$3,000	Not applicable	Individual: \$6,350 Family: \$12,700