

Your summary of benefits



Anthem Blue Cross

Effective: January 1, 2017

Your Plan: University of California High Option Supplement to Medicare

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 High Option Supplement to Medicare Benefit Booklet . If there is a difference between this summary and the UC High Option Supplement to Medicare Benefit Booklet, the UC High Option Supplement to Medicare Benefit Booklet will prevail.*

Covered Medical Benefits	Your Cost
Calendar Year Deductible <i>Deductible applies to non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by this plan. (Medicare Deductible covered in full)</i>	\$50 individual
Calendar Year Out-of-Pocket Limit <i>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 and Medicare covered services not paid by Medicare but paid by this plan. When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>	\$1,050 individual (includes deductible)
Doctor Home and Office Services	
Preventive care/screening/immunization	No charge
Primary care visit to treat an injury or illness	No charge
Specialist care visit	No charge
Prenatal and Post-natal Care	No charge
Other practitioner visits: Chiropractor services Acupuncture <i>Coverage is limited to 24 visit limit per benefit period. These services are not covered by Medicare.</i>	No charge 20% coinsurance
Other services in an office: Allergy testing Chemo/radiation therapy Hemodialysis Office based injectables <i>For the drugs itself dispensed in the office thru infusion/injection when covered by Medicare Part B</i>	No charge No charge No charge No charge

Your summary of benefits

Covered Medical Benefits	Your Cost
Diagnostic Services Lab: Office Freestanding Lab Outpatient Hospital	No charge No charge No charge
X-ray: Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge
Emergency and Urgent Care Emergency room facility services Emergency room doctor and other services	No charge No charge
Ambulance (air and ground)	No charge
Urgent Care (office setting)	No charge
Outpatient Mental/Behavioral Health and Substance Abuse Doctor office visit when covered by Medicare Doctor office visit when not covered by Medicare <i>Deductible applies</i> Facility fees	No charge 20% coinsurance No charge

Your summary of benefits

Covered Medical Benefits	Your Cost
<p>Outpatient Surgery</p> <p>Facility fees:</p> <ul style="list-style-type: none"> Hospital Freestanding Surgical Center <p>Doctor and other services</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>
<p>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</p> <p>Facility fees (for example, room & board)</p> <p>Facility fees beyond lifetime reserve</p> <p>Facility fees beyond the additional 365 days</p> <p>Doctor and other services</p>	<p>No charge</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>No charge</p>
<p>Recovery & Rehabilitation</p> <p>Home health care</p>	<p>No charge</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <ul style="list-style-type: none"> Office Outpatient hospital Habilitation services 	<p>No charge</p> <p>No charge</p> <p>No charge</p>
<p>Cardiac rehabilitation</p> <ul style="list-style-type: none"> Office Outpatient hospital 	<p>No charge</p> <p>No charge</p>
<p>Skilled nursing care (in a facility)</p> <ul style="list-style-type: none"> 21st through 100th day 101st day and after 	<p>No charge</p> <p>Not covered</p>
<p>Hospice</p>	<p>No charge</p>
<p>Durable Medical Equipment</p>	<p>No charge</p>

Your summary of benefits

Covered Medical Benefits	Your Cost
Prosthetic Devices	No charge
Hearing Aids <i>Coverage is limited to 2 hearing aids per 36 months. These services are not covered by Medicare.</i>	20% coinsurance

Your summary of benefits

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