UC Health Savings Plan (HSP)

Your Network: Anthem Preferred Effective: January 1, 2019

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, refer to the UC Health Savings Plan Benefit Booklet, which can be found on the ucppoplans.com website. 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.

ANNUAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS	Anthem Preferred Provider	Out-of-Network Provider
Calendar Year Medical Deductible [1] • In-network deductible accumulates towards Out-of-Network deductible. However, Out-of-Network deductible does not accumulate towards In-network deductible. • The individual deductible only applies to individuals enrolled in individual coverage. • The deductible cost shares of all family members apply to the family deductible.	$1,350 for Individual / $2,700 for Family	$2,550 for Individual / $5,100 for Family
Calendar Year Out-of-Pocket-Maximum[2] • Pharmacy coinsurance counts toward the medical Out-of-Pocket maximum. • In-network Out-of-Pocket accumulates towards Out-of-Network Out-of-Pocket. However, Out-of-Network Out-of-Pocket costs do not accumulate towards the In-Network Out-of-Pocket maximum. • Out-of-Pocket costs for all family members apply to the family Out-of-Pocket maximum. • The individual Out-of-Pocket maximum only apply to individuals enrolled in individual coverage.	$4,000 for individual / $6,400 for family	$8,000 for individual / $16,000 for family
Benefit Lifetime Maximum	Unlimited	Unlimited
COVERED MEDICAL BENEFITS[3]	**MEMBER COPAYMENT/COINSURANCE[4]**	
Doctor Home Visits & Office Services • Preventive care/screening/immunization[5] • Primary care visit to treat an injury or illness • Specialist care visit	• No Charge • 20% • 20%	• 40% • 40% • 40%
Prenatal and Post-natal Care	20%	40%
Other Practitioner Visits: • Retail health clinic • Chiropractor/Acupuncture services[6] *(Coverage for all providers is limited to 24 combined visits covered per calendar year.)*	20%	40%
• LiveHealth Online **(www.livehealthonline.com)** (Virtual doctor and therapist visits)	20%	N/A
Other services in an office: • Office-based injectable *(For the drug itself if dispensed in the office through infusion/injection.)* • Allergy testing and treatment • Allergy serum purchased separately for treatment *(billed separately from office visit)* • Chemo/radiation therapy • Hemodialysis	• 20% • 20% • 20% • 20% • 20%	• 40% • 40% • 40% • 40% • 40%

Diagnostic Services[7] **Lab and X-ray:** • Office • Freestanding Lab[8] • Outpatient Hospital *(Out-of-Network Providers are subject to a maximum payment of $210 per visit.)*	• 20% • 20% • 20%	• 40% • 40% • 40%
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): • Office • Freestanding Lab • Outpatient Hospital *(Out-of-Network Providers are subject to a maximum payment of $210 per visit.)*	• 20% • 20% • 20%	• 40% • 40% • 40%
Emergency Care Coverage • Emergency room facility services • Emergency room doctor and other services • Ambulance (air and ground)	• 20% • 20% • 20%	• 20% • 20% • 20%
Urgent Care (office setting)	• 20%	• 40%
Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse • Doctor office visit • Facility visit	• 20% • 20%	• 40% • 40%
Outpatient Surgery[9] **Facility fees:** • **Hospital** *(Out-of-Network Providers are subject to a maximum payment of $210 per visit).* • **Freestanding Surgical Center** *(Out-of-Network Providers are subject to a maximum payment of $210 per visit).* • **Doctor and other services**	• 20% • 20% • 20%	• 40% • 40% • 40%
Hospital Stay[10] *(most inpatient stays including maternity)* • **Facility fees (for example, room & board)** *(An additional $250 copay may apply if you do not receive preauthorization for Out-of-Network Providers. Out-of-Network Providers are subject to a maximum payment of $360 per day.)* • **Bariatric surgery**[11] *(Prior authorization required, medically necessary surgery for weight loss, for morbid obesity only)* • **Doctor and other services**	• 20% • 20% • 20%	• 40% • Not Covered • 20%
Recovery & Rehabilitation **Home health care** *Coverage for all providers is limited to 100 visits per calendar year. (If pre-authorized, Out-of-Network may be paid at the Anthem Preferred Provider coinsurance level.)*	20%	Not Covered
Rehabilitation services (for example, physical/speech/occupational therapy): • Office (*Costs may vary by site of service.)* • Outpatient hospital *(Out-of-Network Providers are subject to a maximum payment of $210 per visit.)* • Habitation services • Speech Therapy	• 20% • 20% • 20% • 20%	• 40% • 40% • 40% • 20%

Cardiac rehabilitation • Office (*Costs may vary by site of service.)* • Outpatient hospital *(Out-of-Network Providers are subject to a maximum payment of $210 per visit.)*	• 20% • 20%	• 40% • 40%
Skilled nursing care (in a facility)[12] *Coverage for all providers is limited to 100 visits per calendar year. Additional $250 copay for Out-of-Network providers if prior authorization is not obtained.*	20%	40%
Hospice *(If pre-authorized, Out-of-Network may be paid at the Anthem Preferred Provider coinsurance level.)*	20%	Not covered
• **Durable Medical Equipment** • **Hearing Aids** *(Limited to $2,000 per 36 months)*	• 20% • 50%	• 40% • 50%
Prosthetic Devices	20%	40%
Diabetes Care Benefits: • Devices, equipment and supplies • Diabetes self-management training – office location	• 20% • 20%	• 40% • 40%
Travel Immunizations • ACA Travel Immunizations • Non-ACA Travel Immunizations *(Refer to your plan Benefit Booklet for more information on covered vaccinations and immunizations.)*	• No Charge (deductible does not apply) • 20%	• 40% • 40%
Infertility services Diagnosis of cause of Infertility *(Not covered - treatment of infertility, in-vitro fertilization, injectables for infertility, artificial insemination, GIFT and ZIFT)*	20%	40%
Family Planning • Counseling and consulting *(Including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives.)* • Tubal ligation *(An additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility.)* • Vasectomy	• No Charge (deductible does not apply) • No Charge (deductible does not apply) • 20%	• 40% • 40% • 40%
CARE OUTSIDE OF CALIFORNIA		
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 Preferred level of the local Blue Plan allowable amount when you use an Anthem Blue Cross provider	
Outside of US: Blue Cross Blue Shield Global Core	All covered services for urgent and emergency care will be eligible for reimbursement when received outside the US. Please refer to the Anthem Preferred Tier for covered services and corresponding member liability.	

[1] All medical services subject to a coinsurance are also subject to the annual medical deductible unless otherwise noted.

[2] Annual Out-of-Pocket Maximums includes deductibles, coinsurance and prescription drugs, unless otherwise noted.

[3] 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

[4] Unless otherwise specified, coinsurance is calculated based on allowable amounts. Anthem Preferred providers agree to accept Anthem Blue Cross allowable amount plus the plan's and any applicable member's payment as full payment for covered services. Out-of-Network providers can charge more than these amounts. When members use Out-of-Network providers, they must pay the applicable deductibles or coinsurance plus any amount that exceeds Anthem Blue Cross allowable amounts. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.

[5] For more information on what preventive services are covered, visit www.anthem.com/ca/preventive-care.

[6] Visit count starts accruing regardless of if deductible is met or not.

[7] You may incur an additional copay if separate unique professional services are performed by the same or different provider.

[8] Freestanding Lab services must be received in a non-hospital-based facility

[9] 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.

[10] Transplants covered only when performed at Centers of Medical Excellence of Blue Distinction Centers.

[11] Bariatric surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.

[12] Skilled nursing facility day limit does not apply to mental health and substance abuse. Visit count starts accruing regardless if deductible is met or not.