Your summary of benefits

Anthem Blue Cross
Your Plan: University of California UC Care Plan
Your Network: UC Select and Anthem Preferred

Effective: January 1, 2021

See Notes section for important plan information

Covered Medical Benefits	Cost if you use a UC Select Provider	Cost if you use an Anthem Preferred Provider	Cost if you use an Out-of-Network Provider
Calendar Year Deductible	None	$500 individual / $1,000 family	$750 individual / $1,750 family
Calendar Year Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost shares during the remainder of the Calendar Year.*	$6,100 individual / $9,700 family	$7,600 individual / $14,200 family	$9,600 individual / $20,200 family
Doctor Home and Office Services			
Preventive care/screening/immunization	No charge	No charge	50% coinsurance
Primary care visit to treat an injury or illness	$20 copay per visit	30% coinsurance	50% coinsurance
Specialist care visit	$20 copay per visit	30% coinsurance	50% coinsurance
Prenatal and Post-natal Care	$20 copay per visit *(initial visit only)*	30% coinsurance (global pregnancy bill)	50% coinsurance (global pregnancy bill)
Other practitioner visits			
Retail health clinic	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
LiveHealth Online *(www.livehealthonline.com)*	$20 copay per consult (deductible waived)		N/A
Chiropractor services - *Coverage for all providers is limited to 24 visits per calendar year. Combined with acupuncture.*	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Acupuncture - *Coverage for all providers is limited to 24 visits per calendar year. Combined with chiropractor services.*	N/A (services covered under Anthem Preferred)	30% coinsurance	30% coinsurance
Other services in an office			
Allergy testing	$20 copay per visit	30% coinsurance	50% coinsurance
Allergy serum *(billed separately from office visit)*	20% coinsurance	30% coinsurance	50% coinsurance
Chemo/radiation therapy	$20 copay per visits	30% coinsurance	50% coinsurance
Dialysis/Hemodialysis	$20 copay per visits	30% coinsurance	50% coinsurance
Office based injectables - *For the drug itself dispensed in the office through infusion/injection*	No charge	30% coinsurance	50% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use a UC Select Provider	Cost if you use an Anthem Preferred Provider	Cost if you use an Out-of-Network Provider
Diagnostic Services			
Lab: Note - you may incur an additional copay if separate unique professional services are performed by the same or different provider.			
Office	$20 copay per visit	30% coinsurance	50% coinsurance
Freestanding Lab	$20 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	$20 copay per visit	30% coinsurance	50% coinsurance
X-ray: Note - you may incur an additional copay if separate unique professional services are performed by the same or different provider.			
Office	$20 copay per visit	30% coinsurance	50% coinsurance
Freestanding Radiology Center	$20 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	$20 copay per visit	30% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):			
Office	$20 copay per visit	30% coinsurance	50% coinsurance
Freestanding Radiology Center	$20 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	$20 copay per visit	30% coinsurance	50% coinsurance
Emergency and Urgent Care			
Emergency room facility services *Deductible does not apply.*	$300 copay per visit	$300 copay per visit	$300 copay per visit
Emergency room doctor and other services	No charge	No charge	No charge
Ambulance (air and ground)	N/A (services covered under Anthem Preferred)	$200 copay per trip (deductible waived)	$200 copay per trip (deductible waived)
Urgent Care (office setting) *You may incur an additional copay if separate unique professional services are performed by the same or different provider.*	$20 copay per visit	$20 copay per visit (deductible waived)	50% coinsurance
Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse *Deductible is waived for services by Anthem Preferred Providers.*			
Doctor office visit	Visit 1-3: No charge; Visit 4+: $20 copay per visit		50% coinsurance
Facility visit:			
Outpatient facility fees	$20 copay per visit		50% coinsurance
Inpatient facility fees	$250 copay per admission		50% coinsurance
Outpatient Surgery			
Facility fees:			
Hospital or Freestanding Surgical Center	$100 per surgery	30% coinsurance	50% coinsurance
Doctor and other services	No charge	30% coinsurance	50% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use a UC Select Provider	Cost if you use an Anthem Preferred Provider	Cost if you use an Out-of-Network Provider
Hospital Stay (most inpatient stays including maternity)			
Facility fees (for example, room & board)	$250 per admission	30% coinsurance	50% coinsurance
Bariatric surgery *(Medically necessary surgery for weight loss, for morbid obesity only)*	$250 per admission	30% coinsurance	Not covered
Doctor and other services	No charge	30% coinsurance	50% coinsurance
Recovery & Rehabilitation			
Home health care *Coverage is limited to 100 visit limit per Calendar Year.*	N/A (services covered under Anthem Preferred)	30% coinsurance	Not covered
Rehabilitation/Habilitation services (for example, physical/speech/occupational therapy):			
Office - *Costs may vary by site of service.*	$20 copay per visit	30% coinsurance	50% coinsurance
Outpatient hospital	$20 copay per visit	30% coinsurance	50% coinsurance
Cardiac rehabilitation			
Office	$20 copay per visit	30% coinsurance	50% coinsurance
Outpatient hospital	$20 copay per visit	30% coinsurance	50% coinsurance
Skilled Nursing Care (in a facility) *Coverage for all providers is limited to 100 days per calendar year.*	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Hospice	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Durable Medical Equipment	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Prosthetic Devices	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Hearing Aids *(limited to $2000 per 36 months)*	N/A (services covered under Anthem Preferred)	50% coinsurance	50% coinsurance
Diabetes Care Benefits			
Devices, equipment and supplies	20% coinsurance	30% coinsurance	50% coinsurance
Diabetes self-management training – office location *(if billed by your provider, you will also be responsible for the office visit copayment)*	$20 copay per visit	30% coinsurance	50% coinsurance
Travel Immunizations *Refer to your plan benefit booklet for more information on covered vaccinations and immunizations.*	No charge	No charge (deductible waived)	50% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use a UC Select Provider	Cost if you use an Anthem Preferred Provider	Cost if you use an Out-of-Network Provider
Infertility services Diagnosis of cause of Infertility *(Not covered - treatment of infertility, in-vitro fertilization, injectables for infertility, artificial insemination, GIFT and ZIFT)*	20% coinsurance	30% coinsurance	50% coinsurance
Family Planning Counseling and consulting *(Including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives.)*	No charge	No charge	50% coinsurance
Tubal ligation *(an additional facility copayment may apply when services are rendered in a hospital)*	No charge	No charge	50% coinsurance
Vasectomy *(an additional facility copayment may apply when services are rendered in a hospital)*	20% coinsurance	30% coinsurance	50% coinsurance
Care Outside of Plan Service Area			
Within the United States: 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 In-Network provider.		
Outside of the United States: Blue Cross Blue Shield Global Core	All covered services for emergency and non-emergency care will be eligible for reimbursement when received outside the US. Please refer to the Anthem Preferred Tier for covered services. Most services will be subject to the Anthem Preferred Deductible and 20% coinsurance; flat copays will apply when indicated.		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	None	None
Pharmacy Out of Pocket	Combined with Medical, UC Select Maximum	Combined with Medical
Prescription Drug Coverage – *This plan uses the Essential 4-Tier Drug List. Drugs not on the list are not covered. Please refer to the drug list at www.anthem.com/ca/pharmacyinformation to determine which Tier(s) apply to your prescription(s).*		
Retail Pharmacies – up to a 30 day supply		
Tier 1 – Typically Generic	$5 copay per prescription	50% coinsurance per prescription
Tier 2 – Typically Preferred/Brand	$25 copay per prescription	50% coinsurance per prescription
Tier 3 – Typically Non-Preferred / Some Specialty Drugs	$40 copay per prescription	50% coinsurance per prescription

Anthem

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
UC Pharmacies, Specified Pharmacies*, and Home Delivery Pharmacy – up to 90 day supply When you get a 90-day supply, two (2) retail pharmacy copayments per prescription order will apply		
Tier 1 – Typically Generic	$10 copay per prescription	Not covered
Tier 2 – Typically Preferred/Brand	$50 copay per prescription	Not covered
Tier 3 – Typically Non-Preferred / Some Specialty Drugs	$80 copay per prescription	Not covered
Retail90 Pharmacies – up to 90 day supply When you get a 90-day supply, three (3) retail pharmacy copayments per prescription order will apply.		
Tier 1 – Typically Generic	$15 copay per prescription	Not covered
Tier 2 – Typically Preferred/Brand	$75 copay per prescription	Not covered
Tier 3 – Typically Non-Preferred / Some Specialty Drugs	$120 copay per prescription	Not covered
IngenioRx Specialty Pharmacy and Select UC Pharmacies – up to a 30 day supply		
Tier 4 – Typically Specialty Drugs	30% coinsurance to a maximum of $150 per prescription	Not covered
Contraceptive Drugs and Devices *Up to a 12-month supply of contraceptive drugs when dispensed or furnished at one time.*	$0 copay per prescription	$0 copay per prescription (retail only)
Smoking Cessation Products *Over-the Counter Drugs with prescription and Prescription Drugs*	$0 copay per prescription	Not covered
Diabetic Supplies *Including lancets, alcohols swabs, and formulary test strips. (Syringes, needles, insulin, and non-formulary test strips, if approved, are covered at the applicable copay or coinsurance)*	$0 copay per prescription	50% coinsurance (retail only)
Travel Immunizations *Hepatitis A, Hepatitis B, Meningitis, Polio, Japanese Encephalitis, Rabies, Typhoid and Yellow Fever*	$0 copay per prescription	50% coinsurance

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 Care Benefit Booklet. If there is a difference between this summary and the UC Care Benefit Booklet, the UC Care Benefit Booklet, will prevail.

Notes:

- Calendar Year Out-of-Pocket Maximums includes deductible, coinsurance and prescription drug.
- An additional $250 copay applies if prior authorization is not obtained for Inpatient or Skilled Nursing Facility services by an Out-of-Network provider.
- Inpatient Hospital services by an Out-of-Network provider are subject to a maximum plan payment of $300 per day except for services for Mental/Behavioral Health and Substance Abuse.
- Outpatient Hospital services by an Out-of-Network provider are subject to a maximum plan payment of $175 per visit.
- If you use an Out-of-Network provider, you are responsible for any difference between the covered expense and the actual Out-of-Network providers charge.
- All services subject to a coinsurance are also subject to the annual deductible unless otherwise noted.
- UC Select and Anthem Preferred out-of-pocket maximums cross accumulate. However, out of network deductible and out of pocket maximum do not accumulate towards UC Select and Anthem Preferred.
- Calendar Year Out-of-Pocket Limit for Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse services by Anthem Preferred Providers will be $6,100 individual/ $9,700 family.
- Preventive Care services include 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.
- For UC Select office visits, the copay applies to the actual office visit and additional cost shares may apply for other services performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- If you are directly admitted to a hospital, your emergency room facility copay is waived.
- Services from Out-of-Network providers for home health care and hospice services are not covered unless prior authorized. When these or skilled nursing facility services are prior authorized, the member's copayment or coinsurance may be calculated at the Anthem Preferred level, based upon the agreed rate between Anthem Blue Cross and the agency.
- 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. Details are included in the Benefit Booklet.
- Visit limits start accruing regardless if deductible is met or not.
- All services with calendar/plan year limits are combined for both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence of Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- When using non-network pharmacy, members are responsible for 50% of the prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service for information.
- Certain drugs require pre-authorization approval to obtain coverage.
- *Specified Pharmacies are Costco, Safeway/Vons, Walgreens, and CVS
- Through Retail90, you can get a 90-day supply of medication from a participating retail pharmacy for three (3) copays. The Retail90 network includes major retail chains like Rite Aid, and Wal-Mart.
- Specialty drugs are specific drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers and other conditions that are difficult to treat with

traditional therapies. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscular), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration and may require prior authorization for Medical Necessity. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

- Specialty Drugs are covered only when dispensed through IngenioRx and certain UC pharmacies unless Medically Necessary for a covered emergency.
- Specialty Drugs are limited to a quantity not to exceed a 30-day supply; however initial prescriptions for select specialty medications may be limited to a quantity not to exceed a 15-day supply through IngenioRx. In such circumstances the applicable specialty drug will be pro-rated based upon the number of day supply.
- 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.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.