Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Effective: January 1, 2020

Your Plan: University of California CORE Plan

Your Network: Anthem Prudent Buyer PPO

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

Benefit Lifetime Maximum: Unlimited

A description of the prescription drug coverage is provided separately.

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use a Out-of-Network Provider
Calendar Year Deductible *Combined with prescription deductible. See notes section to understand how your deductible works. (All providers combined)*	$3,000 individual	
Calendar Year Out-of-Pocket Limit *Combined with prescription out-of-pocket. When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. (All providers combined)*	$6,350 individual / $12,700 family	
Doctor Home and Office Services		
Preventive care/screening	No charge	20% coinsurance
ACA immunizations	No charge	20% coinsurance
Non-ACA immunizations	20% coinsurance	20% coinsurance
Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance
Specialist care visit	20% coinsurance	20% coinsurance
Prenatal and Post-natal Care	20% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use a Out-of-Network Provider
Other practitioner visits:		
Retail health clinic	20% coinsurance	20% coinsurance
On-line Visit *(LiveHealth Online. www.livehealthonline.com)*	20% coinsurance	N/A
Chiropractor services *Coverage for all providers is limited to 24 visits per calendar year. Combined with acupuncture.*	20% coinsurance	20% coinsurance
Acupuncture *Coverage for all providers is limited to 24 visits per calendar year. Combined with chiropractor services.*	20% coinsurance	20% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	20% coinsurance
Allergy serum purchased separately for treatment *(billed separately from office visit)*	20% coinsurance	20% coinsurance
Chemo/radiation therapy	20% coinsurance	20% coinsurance
Hemodialysis	20% coinsurance	20% coinsurance
Office based injectables *For the drug itself dispensed in the office through infusion/injection*	20% coinsurance	20% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	20% coinsurance
Freestanding Lab	20% coinsurance	20% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance
X-ray:		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center	20% coinsurance	20% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use a Out-of-Network Provider
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center	20% coinsurance	20% coinsurance
Outpatient Hospital *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance
Emergency and Urgent Care		
Emergency room facility services	20% coinsurance	20% coinsurance
Emergency room doctor and other services	20% coinsurance	20% coinsurance
Ambulance (air and ground) ***(not subject to the calendar year deductible)***	20% coinsurance	20% coinsurance
Urgent Care (office setting)	20% coinsurance	20% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance	20% coinsurance
Facility visit:		
Facility fees	20% coinsurance	20% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance
Freestanding Surgical Center *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance
Doctor and other services	20% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use a Out-of-Network Provider
Hospital Stay (all inpatient stays including maternity, mental/ behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Out-of-Network Providers are subject to a maximum payment of $480 per day. If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay.*	20% coinsurance	20% coinsurance
Bariatric surgery *(Prior authorization required, medically necessary surgery for weight loss, for morbid obesity only)*	20% coinsurance	Not covered
Doctor and other services	20% coinsurance	20% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage is limited to 100 visit limit per Calendar Year. (If pre-authorized, Out-of-Network may be paid at the Anthem Prudent Buyer PPO coinsurance level.)*	20% coinsurance	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service.*	20% coinsurance	20% coinsurance
Outpatient hospital *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance
Habilitation services	20% coinsurance	20% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	20% coinsurance
Outpatient hospital *Out-of-Network Providers are subject to a maximum payment of $280 per visit.*	20% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use a Out-of-Network Provider
Skilled nursing care (in a facility) *Coverage for all providers is limited to 100 day limit per Calendar Year. Additional $250 copay for Out-of-Network providers if prior authorization is not obtained.*	20% coinsurance	20% coinsurance
Hospice *(If pre-authorized, Out-of-Network may be paid at the Anthem Prudent Buyer PPO coinsurance level.)*	20% coinsurance	Not covered
Durable Medical Equipment	20% coinsurance	20% coinsurance
Prosthetic Devices	20% coinsurance	20% coinsurance
Hearing Aids	Not covered	Not covered
Diabetes Care Benefits: Devices, equipment and supplies Diabetes self-management training – office location	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Travel Immunizations ACA Travel immunizations Non-ACA Travel immunizations: Japanese Encephalitis, Rabies, Typhoid, and Yellow Fever	 No charge 20% coinsurance	 20% coinsurance 20% coinsurance
Family Planning. Counseling and consulting *(includes insertion of IUD, as well as injectable and implantable contraceptives for women)* Tubal ligation *(an additional facility copayment may apply when services are rendered in a hospital)* Vasectomy *(an additional facility copayment may apply when services are rendered in a hospital)*	No charge No charge 20% coinsurance	20% coinsurance 20% coinsurance 20% coinsurance

Care Outside of Plan Service Area

• 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 Blue Cross Prudent Buyer 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 emergency and non-emergency care will be eligible for reimbursement when received outside the US. Please refer to the Anthem Blue Cross Prudent Buyer level of benefits for covered services and corresponding member liability.

Your summary of benefits

Notes:

- If you use an Out-of-Network Provider, you are responsible for any difference between the covered expense and the actual Non-Participating provider's charge.
- 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible unless otherwise noted.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- Services from Out-of-Network providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member's copayment or coinsurance may be calculated at the Participating provider 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.
- 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 or 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.
- 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.

CA/L/F/PPO/LP2091 /01-16 C-