Your summary of benefits

Anthem Blue Cross
Your Plan: University of California Health Savings Plan (HSP)
Your Network: Anthem Prudent Buyer PPO

Effective: January 1, 2021

See Notes section for important plan information

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use an Out-of-Network Provider
Calendar Year Deductible *The family deductible is non-embedded meaning the cost shares of all family members apply to one shared family deductible. The individual deductible only applies to individuals enrolled under single coverage.*	$1,400 Individual / $2,800 Family	$2,550 Individual / $5,100 Family
Calendar Year Out-of-Pocket Limit *The family out-of-pocket maximum is non-embedded meaning the cost shares of all family members apply to one shared family out-of-pocket maximum. The individual out-of-pocket maximum only applies to individuals enrolled under single coverage. When you meet your out-of-pocket limit, you will no longer have to pay cost shares during the remainder of the Calendar Year.*	$4,000 Individual / $6,400 Family	$8,000 Individual / $16,000 Family
Doctor Home and Office Services		
Preventive care/screening/immunization	No charge	40% coinsurance
Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance
Specialist care visit	20% coinsurance	40% coinsurance
Prenatal and Post-natal Care	20% coinsurance	40% coinsurance
Other practitioner visits		
Retail health clinic	20% coinsurance	40% coinsurance
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	40% 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	40% coinsurance
Allergy serum *(billed separately from office visit)*	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Office based injectables - *For the drug itself dispensed in the office through infusion/injection*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance

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X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Emergency room facility services, doctor, and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting)	20% coinsurance	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance	40% coinsurance
Facility fees	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental/ behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance	40% coinsurance
Bariatric surgery *(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*	20% coinsurance	Not covered
Rehabilitation/Habilitation services (for example, physical/occupational therapy):		
Office - *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Speech therapy	20% coinsurance	20% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Skilled Nursing Care *Coverage for all providers is limited to 100 days per calendar year*		
Hospital	20% coinsurance	40% coinsurance
Freestanding SNF	20% coinsurance	20% coinsurance

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Hospice	20% coinsurance	Not covered
Durable Medical Equipment	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Hearing Aids *(limited to $2000 per 36 months)*	50% coinsurance	50% coinsurance
Diabetes Care Benefits		
Devices, equipment and supplies	20% coinsurance	40% coinsurance
Diabetes self-management training – office location	20% coinsurance	40% coinsurance
Travel Immunizations		
ACA Travel immunizations	No charge	40% coinsurance
Non-ACA Travel immunizations: Japanese Encephalitis, Rabies, Typhoid, and Yellow Fever	20% coinsurance	40% coinsurance
Family Planning		
Counseling and consulting *(includes insertion of IUD, as well as injectable and implantable contraceptives for women)*	No charge	40% coinsurance
Tubal ligation *(an additional facility copayment may apply when services are rendered in a hospital)*	No charge	40% coinsurance
Vasectomy *(an additional facility copayment may apply when services are rendered in a hospital)*	20% coinsurance	40% 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 Prudent Buyer PPO level of the local Blue Plan allowable amount when you use an Anthem Blue Cross provider.	
Outside of the United States: Blue Cross Blue Shield Global Core	All covered services for emergency care will be eligible for reimbursement when received outside the US. Please refer to the Anthem Prudent Buyer PPO level of benefits for covered services and corresponding member liability.	

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with Medical	Combined with Medical
Pharmacy Out of Pocket	Combined with Medical	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).		

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Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Retail Pharmacies – up to a 30 day supply		
Tier 1 – Typically Generic	20% coinsurance per prescription	40% coinsurance per prescription
Tier 2 – Typically Preferred/Brand	20% coinsurance per prescription	40% coinsurance per prescription
Tier 3 – Typically Non-Preferred / Some Specialty Drugs	20% coinsurance per prescription	40% coinsurance per prescription
Home Delivery Pharmacy, UC Pharmacies, Retail90 Pharmacies – up to a 90 day supply		
Tier 1 – Typically Generic	20% coinsurance per prescription	Not covered
Tier 2 – Typically Preferred/Brand	20% coinsurance per prescription	Not covered
Tier 3 – Typically Non-Preferred / Some Specialty Drugs	20% coinsurance per prescription	Not covered
IngenioRx Specialty Pharmacy and Select UC Pharmacies – up to a 30 day supply#		
Tier 4 – Typically Specialty Drugs *$200 maximum per prescription for Oral Anti-Cancer medications*	20% coinsurance 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 (deductible waived)	Not covered
Smoking Cessation Products *Over-the Counter Drugs with prescription and Prescription Drugs*	$0 copay per prescription (deductible waived)	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 coinsurance)*	$0 copay per prescription (after deductible)	40% coinsurance (retail only)
Travel Immunizations		
• *ACA Preventive: Hepatitis A, Hepatitis B, Meningitis, Polio*	$0 copay per prescription (deductible waived)	40% coinsurance
• *Other Travel: Japanese Encephalitis, Rabies, Typhoid and Yellow Fever*	20% coinsurance	40% 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 Health Savings Plan Benefit Booklet. 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.

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 $360 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 $210 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 medical deductible unless otherwise noted.
- In network deductible and out of pocket maximums accumulate towards out of network deductible and out of pocket maximums. However, out of network deductible and out of pocket maximum do not accumulate towards In-network.
- 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.
- 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 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.
- 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.
- When using non-network pharmacy; members are responsible for 40% 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.
- The Retail90 network includes major chains like Costco, Safeway/Vons, Walgreens, CVS, 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.

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