

Your summary of benefits



Anthem Blue Cross
 Your Plan: University of California CORE Plan
 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 <i>All providers combined.</i>	\$3,000 individual	
Calendar Year Out-of-Pocket Limit <i>All providers combined. When you meet your out-of-pocket limit, you will no longer have to pay cost shares during the remainder of the Calendar Year.</i>	\$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
Other practitioner visits		
Retail health clinic	20% coinsurance	20% 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	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 (<i>billed separately from office visit</i>)	20% coinsurance	20% coinsurance
Chemo/radiation therapy	20% coinsurance	20% coinsurance
Hemodialysis	20% coinsurance	20% coinsurance
Office based injectables - <i>For the drug itself dispensed in the office through infusion/injection</i>	20% coinsurance	20% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	20% coinsurance
Freestanding Lab	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
X-ray:		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance

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Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use an Out-of-Network Provider
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance 20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance 20% coinsurance
Emergency and Urgent Care Emergency room facility services, doctor and other services	20% coinsurance	20% coinsurance
Ambulance (air and ground) <i>Not subject to the calendar year deductible</i>	20% coinsurance	20% coinsurance
Urgent Care (office setting)	20% coinsurance	20% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse Doctor office visit Facility fees	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Outpatient Surgery Facility fees: Hospital Freestanding Surgical Center Doctor and other services	20% coinsurance 20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance 20% coinsurance
Hospital Stay (all inpatient stays including maternity, mental/behavioral health, and substance abuse) Facility fees (for example, room & board) Bariatric surgery <i>(Medically necessary surgery for weight loss, for morbid obesity only)</i> Doctor and other services	20% coinsurance 20% coinsurance 20% coinsurance	20% coinsurance Not covered 20% coinsurance
Recovery & Rehabilitation Home health care <i>Coverage is limited to 100 visit limit per Calendar Year.</i>	20% coinsurance	Not covered
Rehabilitation/Habilitation services (for example, physical/speech/occupational therapy): Office - <i>Costs may vary by site of service.</i> Outpatient hospital	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Cardiac rehabilitation Office Outpatient hospital	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Skilled Nursing Care (in a facility) <i>Coverage for all providers is limited to 100 days per calendar year.</i>	20% coinsurance	20% coinsurance
Hospice	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

Covered Medical Benefits	Cost if you use an Anthem Prudent Buyer PPO Provider	Cost if you use an Out-of-Network Provider
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 <i>(includes insertion of IUD, as well as injectable and implantable contraceptives for women)</i> Tubal ligation <i>(an additional facility copayment may apply when services are rendered in a hospital)</i> Vasectomy <i>(an additional facility copayment may apply when services are rendered in a hospital)</i>	No charge No charge 20% coinsurance	20% coinsurance 20% coinsurance 20% 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 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 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	
Pharmacy Out of Pocket	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	20% coinsurance per prescription	20% coinsurance per prescription
Tier 2 – Typically Preferred/Brand	20% coinsurance per prescription	20% coinsurance per prescription
Tier 3 – Typically Non-Preferred / Some Specialty Drugs	20% coinsurance per prescription	20% coinsurance per prescription

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 <i>\$200 maximum per prescription for Oral Anti-Cancer medications</i>	20% coinsurance per prescription	Not covered
Contraceptive Drugs and Devices <i>Up to a 12-month supply of contraceptive drugs when dispensed or furnished at one time.</i>	\$0 copay per prescription (deductible waived)	Not covered
Smoking Cessation Products <i>Over-the Counter Drugs with prescription and Prescription Drugs</i>	\$0 copay per prescription (deductible waived)	Not covered
Diabetic Supplies <i>Including lancets, alcohol swabs, and formulary test strips. (Syringes, needles, insulin, and non-formulary test strips, if approved, are covered at the applicable coinsurance)</i>	\$0 copay per prescription (after deductible)	20% coinsurance
Travel Immunizations		
<ul style="list-style-type: none"> ACA Preventive: Hepatitis A, Hepatitis B, Meningitis, Polio 	\$0 copay per prescription (deductible waived)	20% coinsurance
<ul style="list-style-type: none"> Other Travel: Japanese Encephalitis, Rabies, Typhoid and Yellow Fever 	20% coinsurance	20% 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 CORE Benefit Booklet. If there is a difference between this summary and the CORE Benefit Booklet, the CORE 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 \$480 per day.
- Outpatient Hospital services by an Out-of-Network provider are subject to a maximum plan payment of \$280 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 provider's charge.
- All services subject to a coinsurance are also subject to the annual deductible unless otherwise noted.
- 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 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. 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 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 20% 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.