

# Your summary of benefits



Anthem Blue Cross

Effective: January 1, 2021

Your Plan: University of California Medicare PPO w/o Rx

Please Note: this medical plan is a complement to your existing Medicare plan. Medicare benefits are primary and then the benefits of this plan are calculated to coordinate up to the Medicare allowable expense.

Covered Medical Benefits	Your Cost
<b>Calendar Year Deductible</b> <i>Deductible applies to Medicare covered services and services not covered by Medicare but covered by this plan. (This Plan also covers Medicare Part A and B Deductibles in full)</i>	\$100 individual
<b>Calendar Year Out-of-Pocket Limit</b> <i>Out-of-Pocket Limit applies to all medical plan Member liability within Medicare allowable amount for Medicare covered services and Plan allowed amounts for non-Medicare covered services that are covered by this Plan. When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of the calendar year. Prescription drug benefits are provided separately.</i>	\$1,500 individual (includes deductible)
<b>Doctor Home and Office Services</b>	
<b>Preventive care/screening/immunization</b> (See details below)	No charge
<b>Primary care visit to treat an injury or illness</b>	20% coinsurance
<b>Specialist care visit</b>	20% coinsurance
<b>Prenatal and Post-natal Care</b>	20% coinsurance
<b>Other practitioner visits:</b> LiveHealth Online ( <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ) - <i>Deductible does not apply. These services are not covered by Medicare.</i>	\$20 copay per visit
Chiropractor services	20% coinsurance
Acupuncture - <i>Coverage is limited to 24 visits per benefit period. These services are not covered by Medicare.</i> Note: Some acupuncture services may be covered by Medicare. See your "Medicare & You" handbook for details.	20% coinsurance
<b>Other services in an office:</b>	
Allergy testing	20% coinsurance
Chemo/radiation therapy	20% coinsurance
Hemodialysis	20% coinsurance
Office based injectables - <i>for the drugs itself dispensed in the office thru infusion/injection when covered by Medicare Part B</i>	20% coinsurance
<b>Diagnostic Services</b>	
<b>Lab:</b>	
Office	20% coinsurance
Freestanding Lab	20% coinsurance
Outpatient Hospital	20% coinsurance
<b>X-ray:</b>	
Office	20% coinsurance
Freestanding Radiology Center	20% coinsurance
Outpatient Hospital	20% coinsurance

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<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b>	
Office	20% coinsurance
Freestanding Radiology Center	20% coinsurance
Outpatient Hospital	20% coinsurance
<b>Emergency and Urgent Care</b>	
Emergency room facility services	20% coinsurance
Emergency room doctor and other services	20% coinsurance
Ambulance (air and ground)	20% coinsurance
Urgent Care (office setting)	20% coinsurance
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b>	
Doctor office visit when covered by Medicare	20% coinsurance
Doctor office visit when not covered by Medicare	20% coinsurance
Facility fees	20% coinsurance
<b>Outpatient Surgery</b>	
Facility fees:	
Hospital or Freestanding Surgical Center	20% coinsurance
Doctor and other services	20% coinsurance
<b>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</b>	
Facility fees (for example, room & board) for first 60 days	No charge
Facility fees 61 <sup>st</sup> through 91 <sup>st</sup> day	20% coinsurance
Facility fees beyond lifetime reserve ( <i>These services are not covered by Medicare</i> )	20% coinsurance
Doctor and other services	20% coinsurance
<b>Recovery &amp; Rehabilitation</b>	
Home health care	20% coinsurance
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>	
Office	20% coinsurance
Outpatient hospital	20% coinsurance
Habilitation services	20% coinsurance
<b>Cardiac rehabilitation</b>	
Office	20% coinsurance
Outpatient hospital	20% coinsurance
<b>Skilled nursing care (in a facility)</b>	
21 <sup>st</sup> through 100 <sup>th</sup> day	20% coinsurance
101 <sup>st</sup> day and after ( <i>These services are not covered by Medicare</i> )	20% coinsurance
<b>Exhausted Medicare Benefits</b>	20% coinsurance
<i>When you have reached a Medicare Benefit limit or cap limit, the Plan will provide additional benefits. See your plan SPD for specific criteria that must be satisfied.</i>	
<b>Hospice</b>	20% coinsurance
<b>Durable Medical Equipment</b>	20% coinsurance
<b>Prosthetic Devices</b>	20% coinsurance
<b>Hearing Aids</b>	20% coinsurance

Coverage is limited to 2 hearing aids per 36 months. These services are not covered by Medicare.

*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 Medicare PPO Without Rx Benefit Booklet. If there is a difference between this summary and the Medicare PPO Without Rx Benefit Booklet, the Medicare PPO Without Rx Benefit Booklet will prevail.*

## Notes:

- Only retirees, or dependents of, enrolled in Medicare parts A & B are eligible for this plan.
- Medicare will always pay primary for Medicare covered services.
- All medical services subject to a coinsurance are also subject to the annual medical deductible unless otherwise noted.
- Annual Out-of-Pocket Maximums include deductible and coinsurance.
- Medicare covers 100% of the cost for the Welcome to Medicare preventive visit and Annual Wellness visits, as well as specific services Medicare considers preventive based on gender and age. (Note that Medicare does not cover what is generally known as a “yearly physical” or “physical exam.”) For more information, go to [medicare.gov](http://medicare.gov). You can also learn more about wellness and preventive coverage by reading a blog on the [UCppoplans.com](http://UCppoplans.com) website. Just go to the site and search for “wellness visits”.
- 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.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health coverage so that the services received from all group coverage do not exceed 100% of the covered expense