

Effective: January 1, 2025

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

See Notes section for important plan information. This document only includes information about medical benefits. Visit uchealthplans.com for information about prescription drug coverage.

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 Combined with pharmacy out-of-pocket costs. 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
The family deductible and out-of-pocket maximum are e applied to both the individual deductible and individual o members apply to both the family deductible and family individual deductible and individual out-of-pocket maxim	ut-of-pocket maximum; out-of-pocket maximum	in addition, amounts for	r all covered 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	\$30 copay per visit	30% coinsurance	50% coinsurance
Specialist care visit	\$30 copay per visit	30% coinsurance	50% coinsurance
Prenatal and Post-natal Care	\$30 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
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

### Your summary of benefits

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Covered Medical Benefits	Cost if you use a	Cost if you use an	Cost if you use an
	UC Select	Anthem Preferred	Out-of-Network
	Provider	Provider	Provider
Other services in an office	<b>*</b> •••	000/	
Allergy testing	\$30 copay per visit	30% coinsurance	50% coinsurance
Allergy serum (billed separately from office	000/		
visit)	20% coinsurance	30% coinsurance	50% coinsurance
Chemo/radiation therapy	\$30 copay per visits	30% coinsurance	50% coinsurance
Dialysis/Hemodialysis	\$30 copay per visits	30% coinsurance	50% coinsurance
Office based injectables - For the drug itself	No charge	30% coinsurance	50% coinsurance
dispensed in the office through			
infusion/injection			
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 oppav por visit	30% coinsurance	50% coinsurance
Freestanding Lab	\$30 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	\$30 copay per visit \$30 copay per visit	30% coinsurance	50% coinsurance
X-ray: Note - you may incur an additional copay if	φου copay per visit		
separate unique professional services are			
performed by the same or different provider.			
Office	\$30 copay per visit	30% coinsurance	50% coinsurance
Freestanding Radiology Center	\$30 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	\$30 copay per visit	30% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example,			
MRI/PET/CAT scans):			
Office	\$30 copay per visit	30% coinsurance	50% coinsurance
Freestanding Radiology Center	\$30 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	\$30 copay per visit	30% coinsurance	50% coinsurance
Emergency and Urgent Care			
Emergency room facility services	\$300 copav per visit	\$300 copay per visit	\$300 copay per visit
Deductible does not apply.			
Emergency room doctor and other services	No charge	No charge	No charge
Ambulance (air and ground)	N/A (services	\$200 copay per trip	\$200 copay per trip
,	covered under	(deductible waived)	(deductible waived)
	Anthem Preferred)	,	,
Urgent Care (office setting)	\$30 copay per visit	\$30 copay per visit	50% coinsurance
You may incur an additional copay if separate		(deductible waived)	
unique professional services are performed by the			
same or different provider.			

### Your summary of benefits

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Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse Deductible is waived for services by Anthem Preferred Providers.     Visit 1-3: No charge; Visit 4-: \$30 copay per visit     50% coinsurance       Doctor office visit     Visit 4-: \$30 copay per visit     50% coinsurance     50% coinsurance       Providers.     State of the services     \$100 per surgery Facility fees     \$0% coinsurance     50% coinsurance       Outpatient facility fees     \$100 per surgery Hospital or Freestanding Surgical Center No charge     \$100 per surgery 30% coinsurance     \$0% coinsurance       Doctor and other services     No charge     30% coinsurance     \$0% coinsurance       Maternity     Facility fees (for example, room & board) Bariatric surgery (Medically necessary surgery for weight loss, for morbid obesity only)     \$250 per admission S250 per admission     30% coinsurance     \$0% coinsurance       Doctor and other services     N/A (services covered under Anthem Preferred)     \$30% coinsurance     \$0% coinsurance       Rebabilitation Home health care Coverage is limited to 100 visits per Calendar Year.     \$30 copay per visit 30% coinsurance     \$30% coinsurance     \$0% coinsurance       Cardiac rehabilitation Office     \$30 copay per visit 30% coinsurance     \$0% coinsurance     \$0% coinsurance       Stilled Nursing Care (in a facility) Coverage for all providers is l	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
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	Durable Medical Equipment		30% coinsurance	50% coinsurance
		Anthem Preferred)		

### Your summary of benefits

# Anthem.

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
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 Diabetes self-management training – office location (if billed by your provider, you will also be responsible for the office visit copayment)	20% coinsurance \$30 copay per visit	30% coinsurance 30% coinsurance	50% coinsurance 50% coinsurance
<b>Travel Immunizations</b> Refer to your plan benefit booklet for more information on covered vaccinations and immunizations.	No charge	No charge (deductible waived)	50% coinsurance
Infertility services			
Diagnosis of cause of Infertility	20% coinsurance	30% coinsurance	50% coinsurance
IVF, ZIFT, and/or GIFT (Limited to 2 cycles per lifetime. Coinsurance for these services does not apply towards Calendar Year Out-of- Pocket Limit)	50% coinsurance	50% 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)	No charge	No charge	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.		

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect 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.

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#### Notes:

- Calendar Year Out-of-Pocket Maximums includes deductible, coinsurance, and prescription drug unless otherwise stated.
- 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, outpatient 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.
- 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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