Your summary of benefits

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

Effective: January 1, 2025

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 embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.			
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

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Other services in an office			
Allergy testing	$30 copay per visit	30% coinsurance	50% coinsurance
Allergy serum *(billed separately from office 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 dispensed in the office through infusion/injection*	No charge	30% coinsurance	50% coinsurance
Diagnostic Services			
Lab: Note - you may incur an additional copay if separate unique professional services are performed by the same or different provider.			
Office	$30 copay per visit	30% coinsurance	50% coinsurance
Freestanding Lab	$30 copay per visit	30% coinsurance	50% coinsurance
Outpatient Hospital	$30 copay per visit	30% coinsurance	50% coinsurance
X-ray: Note - you may incur an additional copay if 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 *Deductible does not apply.*	$300 copay per visit	$300 copay per visit	$300 copay per visit
Emergency room doctor and other services	No charge	No charge	No charge
Ambulance (air and ground)	N/A (services covered under Anthem Preferred)	$200 copay per trip (deductible waived)	$200 copay per trip (deductible waived)
Urgent Care (office setting) *You may incur an additional copay if separate unique professional services are performed by the same or different provider.*	$30 copay per visit	$30 copay per visit (deductible waived)	50% coinsurance

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Outpatient/Inpatient Mental/Behavioral Health and Substance Abuse *Deductible is waived for services by Anthem Preferred Providers.*			
Doctor office visit	Visit 1-3: No charge; Visit 4+: $30 copay per visit		50% coinsurance
Facility visit:			
Outpatient facility fees	$30 copay per visit		50% coinsurance
Inpatient facility fees	$250 copay per admission		50% coinsurance
Outpatient Surgery			
Facility fees:			
Hospital or Freestanding Surgical Center	$100 per surgery	30% coinsurance	50% coinsurance
Doctor and other services	No charge	30% coinsurance	50% coinsurance
Hospital Stay (most inpatient stays including maternity)			
Facility fees (for example, room & board)	$250 per admission	30% coinsurance	50% coinsurance
Bariatric surgery *(Medically necessary surgery for weight loss, for morbid obesity only)*	$250 per admission	30% coinsurance	Not covered
Doctor and other services	No charge	30% coinsurance	50% coinsurance
Recovery & Rehabilitation			
Home health care *Coverage is limited to 100 visits per Calendar Year.*	N/A (services covered under Anthem Preferred)	30% coinsurance	Not covered
Rehabilitation/Habilitation services (for example, physical/speech/occupational therapy):			
Office	$30 copay per visit	30% coinsurance	50% coinsurance
Outpatient hospital	$30 copay per visit	30% coinsurance	50% coinsurance
Cardiac rehabilitation			
Office	$30 copay per visit	30% coinsurance	50% coinsurance
Outpatient hospital	$30 copay per visit	30% coinsurance	50% coinsurance
Skilled Nursing Care (in a facility) *Coverage for all providers is limited to 100 days per calendar year.*	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Hospice	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance
Durable Medical Equipment	N/A (services covered under Anthem Preferred)	30% coinsurance	50% coinsurance

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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
Travel Immunizations *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 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)*	 20% coinsurance 50% coinsurance	 30% coinsurance 50% coinsurance	 50% coinsurance 50% coinsurance
Family Planning Counseling and consulting *(Including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives.)* 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 No charge	 No charge No charge No charge	 50% coinsurance 50% coinsurance 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.

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.