Your summary of benefits

Anthem

Anthem Blue Cross
Your Plan: University of California CORE Plan
Your Network: Anthem Prudent Buyer PPO

Effective: January 1, 2023

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 an Anthem Prudent Buyer PPO Provider	Cost if you use an Out-of-Network Provider
Calendar Year Deductible *Combined with pharmacy deductible. All providers combined.*	$3,000 individual	
Calendar Year Out-of-Pocket Limit *Combined with pharmacy out-of-pocket costs. 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.*	$6,350 individual / $12,700 family	
The family out-of-pocket maximum is 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 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	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
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 *(billed separately from office visit)*	20% coinsurance	20% coinsurance
Chemo/radiation therapy	20% coinsurance	20% coinsurance
Hemodialysis	20% coinsurance	20% coinsurance
Office based injectables - *For the drug itself dispensed in the office through infusion/injection*	20% coinsurance	20% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	20% coinsurance
Freestanding Lab	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance

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X-ray:		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
Emergency and Urgent Care		
Emergency room facility services, doctor, and other services	20% coinsurance	20% coinsurance
Ambulance (air and ground) *Not subject to the calendar year deductible*	20% coinsurance	20% coinsurance
Urgent Care (office setting)	20% coinsurance	20% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance	20% coinsurance
Facility fees	20% coinsurance	20% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	20% coinsurance
Freestanding Surgical Center	20% coinsurance	20% coinsurance
Doctor and other services	20% coinsurance	20% coinsurance
Hospital Stay (all inpatient stays including maternity, mental/ behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance	20% 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 visits per Calendar Year.*	20% coinsurance	Not covered
Rehabilitation/Habilitation services (for example, physical/speech/occupational therapy):		
Office - *Costs may vary by site of service.*	20% coinsurance	20% coinsurance
Outpatient hospital	20% coinsurance	20% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	20% coinsurance
Outpatient hospital	20% coinsurance	20% coinsurance
Skilled Nursing Care (in a facility) *Coverage for all providers is limited to 100 days per calendar year.*	20% coinsurance	20% coinsurance
Hospice	20% coinsurance	Not covered
Durable Medical Equipment	20% coinsurance	20% coinsurance
Prosthetic Devices	20% coinsurance	20% coinsurance

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Hearing Aids	Not covered	Not covered
Diabetes Care Benefits		
Devices, equipment and supplies	20% coinsurance	20% coinsurance
Diabetes self-management training – office location	20% coinsurance	20% coinsurance
Travel Immunizations		
ACA Travel immunizations	No charge	20% coinsurance
Non-ACA Travel immunizations: Japanese Encephalitis, Rabies, Typhoid, and Yellow Fever	20% coinsurance	20% coinsurance
Infertility services		
Diagnosis of cause of Infertility	20% coinsurance	20% 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
Family Planning		
Counseling and consulting *(includes insertion of IUD, as well as injectable and implantable contraceptives for women)*	No charge	20% coinsurance
Tubal ligation *(an additional facility coinsurance may apply when services are rendered in a hospital)*	No charge	20% coinsurance
Vasectomy *(an additional facility coinsurance may apply when services are rendered in a hospital)*	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.	

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 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 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 $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.
- 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.