Your summary of benefits

Anthem

Anthem Blue Cross

Effective: January 1, 2025

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
Calendar Year Deductible *Deductible applies to Medicare covered services and services not covered by Medicare but covered by this plan. (This Plan covers Medicare Part A and B Deductibles in full)*	$100 individual
Calendar Year Out-of-Pocket Limit *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.*	$1,500 individual (includes deductible)
Doctor Home and Office Services	
Preventive care/screening/immunization (See details below)	No charge
Primary care visit to treat an injury or illness	20% coinsurance
Specialist care visit	20% coinsurance
Prenatal and Post-natal Care	20% coinsurance
Other practitioner visits:	
LiveHealth Online (www.livehealthonline.com) - *Deductible does not apply. These services are not covered by Medicare but are covered by your UC plan.*	$20 copay per visit
Chiropractor services	20% coinsurance
Acupuncture - *Coverage is limited to 24 visits per benefit period. These services are not covered by Medicare.* *Note: Some acupuncture services may be covered by Medicare. See your "Medicare & You" handbook for details.*	20% coinsurance
Other services in an office:	
Allergy testing	20% coinsurance
Chemo/radiation therapy	20% coinsurance
Hemodialysis	20% coinsurance
Office based injectables - *for the drugs itself dispensed in the office thru infusion/injection when covered by Medicare Part B*	20% coinsurance
Diagnostic Services	
Lab:	
Office	20% coinsurance
Freestanding Lab	20% coinsurance
Outpatient Hospital	20% coinsurance
X-ray:	
Office	20% coinsurance
Freestanding Radiology Center	20% coinsurance
Outpatient Hospital	20% coinsurance

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Advanced diagnostic imaging (for example, MRI/PET/CAT scans):	
Office	20% coinsurance
Freestanding Radiology Center	20% coinsurance
Outpatient Hospital	20% coinsurance
Emergency and Urgent Care	
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
Outpatient Mental/Behavioral Health and Substance Abuse	
Doctor office visit when covered by Medicare	20% coinsurance
Doctor office visit when not covered by Medicare	20% coinsurance
Facility fees	20% coinsurance
Outpatient Surgery	
Facility fees:	
Hospital or Freestanding Surgical Center	20% coinsurance
Doctor and other services	20% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)	
Facility fees (for example, room & board) for first 60 days **Facility fees 61st through 91st day**	No charge 20% coinsurance
Facility fees beyond lifetime reserve ***(These services are not covered by Medicare but are covered by your UC plan)***	20% coinsurance
Doctor and other services	20% coinsurance
Recovery & Rehabilitation	
Home health care	20% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):	
Office	20% coinsurance
Outpatient hospital	20% coinsurance
Habilitation services	20% coinsurance
Cardiac rehabilitation	
Office	20% coinsurance
Outpatient hospital	20% coinsurance
Skilled nursing care (in a facility) 21st through 100th day 101st day and after *(These services are not covered by Medicare but are covered by your UC plan)*	 20% coinsurance 20% coinsurance
Exhausted Medicare Benefits *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.*	20% coinsurance
Hospice	20% coinsurance
Durable Medical Equipment	20% coinsurance
Prosthetic Devices	20% coinsurance

Hearing Aids *Coverage is limited to 2 hearing aids per 36 months. These services are not covered by Medicare but are covered by your UC plan.*	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 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. You can also learn more about wellness and preventive coverage by reading a blog on the uchealthplans.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