Your summary of benefits

Anthem | STUDENT ADVANTAGE

Anthem Blue Cross

University of California, Los Angeles - Extension

Your Plan: Anthem Student Advantage Custom Premier PPO 250

Your Network: Prudent Buyer PPO

Student Health Center Benefits:
No Charge for Covered Medical Expenses
Deductible Waived

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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Overall Deductible *See notes section to understand how your deductible works.* *In-Network Providers and Out-of-Network Providers deductibles are combined.* *Satisfying one helps satisfy the other.*	$250 single / $500 family	
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,900 single / $15,800 family	$15,800 single / $31,600 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible. Deductible applies to Out-of-Network.*	No Charge	40% coinsurance
Doctor Home and Office Services **Primary care visit to treat an injury or illness** *Deductible applies.*	$25 copay per visit 20% coinsurance	40% coinsurance
Specialist care visit *Deductible applies.*	$25 copay per visit 20% coinsurance	40% coinsurance
Prenatal and Post-natal Care *Deductible applies. No Charge for routine Maternity In-Network.*	20% coinsurance	40% coinsurance

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Other practitioner visits: *Deductible applies.*		
Retail health clinic	20% coinsurance	40% coinsurance
On-line Visit	20% coinsurance	40% coinsurance
Chiropractor services *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	20% coinsurance	40% coinsurance
Acupuncture	20% coinsurance	40% coinsurance
Other services in an office: *Deductible applies.*		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drug itself dispensed in the office thru infusion/injection.*	20% coinsurance	40% coinsurance
Diagnostic Services *Deductible applies.*		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-ray: *Deductible applies.*		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance

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Advanced diagnostic imaging (for example, MRI/PET/CAT scans): *Deductible applies.*		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Deductible applies.*	$150 copay per visit 20% coinsurance	Covered as In-Network
Emergency room doctor and other services *Deductible applies.*	20% coinsurance	Covered as In-Network
Ambulance (air and ground) *Deductible applies.*	20% coinsurance	Covered as In-Network
Urgent Care (office setting) *Deductible applies.*	20% coinsurance	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *Deductible applies.*	$25 copay per visit 20% coinsurance	40% coinsurance
Facility visit: *Deductible applies.*		
Facility fees	20% coinsurance	40% coinsurance
Doctor Services	20% coinsurance	40% coinsurance

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Outpatient Surgery *Deductible applies.*		
Facility fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Doctor and other services *Deductible applies.*		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) *Deductible applies.*		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation *Deductible applies.*		
Home health care *Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 120 visits per benefit period.*	20% coinsurance	40% coinsurance
Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy):		
Office *Deductible does not apply to In-Network charges.*	$25 copay per visit 20% coinsurance	40% coinsurance
Outpatient hospital *Deductible applies.*	$25 copay per visit 20% coinsurance	40% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Cardiac rehabilitation *Deductible applies.*		
Office	$25 copay per visit 20% coinsurance	40% coinsurance
Outpatient hospital	$25 copay per visit 20% coinsurance	40% coinsurance
Skilled nursing care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Out-of-Network Providers combined is limited to 100 days per benefit period. Deductible applies.*	20% coinsurance	40% coinsurance
Hospice *Precertification is required. Deductible does not apply to In-Network providers. Deductible applies to Out-of-Network providers.*	20% coinsurance	40% coinsurance
Durable Medical Equipment *Deductible applies.*	20% coinsurance	40% coinsurance
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network Providers and Out-of-Network Providers combined is limited to 1 items per benefit period. Deductible applies.*	20% coinsurance	40% coinsurance

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision Essential Health Benefits *Limited to covered persons under the age of 19.*		
Vision exam *Includes one exam/fitting per year*	$0 copay	$0 copay (up to $30)
Frames *Includes one per year*	$0 copay, formulary	$0 copay (up to $45)
Lenses *Includes one per year*	$0 copay	$0 copay (up to $25)
Elective contact lenses *Includes one per year*	$0 copay, formulary	$0 copay (up to $60)

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Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Dental Essential Health Benefits *Limited to covered persons under the age of 19.*		
Diagnostic and Preventive services	0% coinsurance	0% coinsurance
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Pharmacy Deductible *Combined with medical.*	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Not applicable
Prescription Drug Coverage *This plan uses a Traditional Drug List. Drugs not on the list are not covered. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$20 copay per prescription	Not covered
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$40 copay per prescription	Not covered
Tier3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$60 copay per prescription	Not covered

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network out of pocket maximum are inclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes 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 Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefits and you use a Out-of-Network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- 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.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.

- If your plan includes out of network benefits, all services with calendar/plan year limits are combined 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.
- Respite Care limited to 5 consecutive days per admission.
- 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.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- If Medically Necessary Prescription Drugs cannot be obtained from the Student Health Center, they may be obtained from an In Network retail Pharmacy. You will pay no more than the same cost sharing that you would pay for those same Drugs obtained from the Student Health Center.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://www11.anthem.com/ca/shared/f0/s0/t0/pw_g385376.pdf
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.