Your summary of benefits

Anthem®

Anthem® Blue Cross Life and Health Insurance Company

Effective Date: July 1, 2026

Your Plan: Regents of the University of California: Modified Premier PPO

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 family	$100 person / $200 family	$200 person / $500 family
Overall Out-of-Pocket Limit	$1,000 person / $2,000 family	$1,000 person / $2,000 family	$2,000 person / $4,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts accumulate separately and do not accumulate toward each other. The deductibles for UCMC Tier 1 and In-Network Tier 2 are separate and do not cross apply. The out-of-pocket maximums for UCMC Tier 1 and In-Network Tier 2 cross apply.			
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*			
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse disorder care via www.livehealthonline.com are covered at $15 copay per visit deductible does not apply; and $15 copay per visit deductible does not apply for covered Specialist Care.*			
Primary Care (PCP) and Mental Health and Substance Abuse Disorder Care *virtual and office*	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care *virtual and office*	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal)	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 60 visits per benefit period.*	Not Applicable	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture *Coverage is limited to 24 visits per benefit period.*	Not Applicable	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Other Services in an Office			
Allergy Testing	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	10% coinsurance	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	No charge	0% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	0% coinsurance after deductible is met
Diagnostic Services			
Lab			
Office	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray			
Office	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*			
Office	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care			
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$15 copay per visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$50 copay per visit	$50 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	No charge	Covered as In-Network
Ambulance	Not Applicable	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Disorder Care at a Facility			
Facility Fees	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery			
Facility Fees			
Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Physician and other services Hospital	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse Disorder) *Member is responsible for an additional $250 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers. Anthem's maximum payment is up to $600 per day for non-emergency Inpatient admissions to non-network providers.*			
Facility Fees	$250 copay per admission	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	Not Applicable	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* Office	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	$15 copay per visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a UCMC Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	Not Applicable	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	Not Applicable	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	Not Applicable	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	Not Applicable	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hearing aids *Coverage is limited to 1 item(s) per ear every 3 years. Limited to $2,000 maximum.*	Not Applicable	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a UCMC Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*			
Tier 1 - Typically Generic	$10 copay per prescription (retail and home delivery)	$10 copay per prescription (retail and home delivery)	50% coinsurance up to $250 per prescription (retail)

Covered Prescription Drug Benefits	Cost if you use a UCMC Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
			and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$20 copay per prescription (retail) and $30 copay per prescription (home delivery)	$20 copay per prescription (retail) and $30 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	$40 copay per prescription (retail) and $50 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Outpatient Facility tests and treatments are limited to $350 per admission for Non-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- The representations of benefits in this document are subject to California Department of Insurance (DOI) approval and are subject to change.

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 Benefit Booklet. If there is a difference between this summary and the Benefit Booklet, the Benefit Booklet, will prevail.

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Get help in your language
Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721.
للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Armenian
Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese
免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡 CA Dept. of Insurance。(TTY/TDD: 711)

Farsi
خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD:711)

Hindi
बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi
ਿਬਨਾਂ ਿਕਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪਰ ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਿਵੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉ ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਿਜ਼ਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਿਡਪਾਰਟਮ ਂਟ ਔਫ ਇਨਸ਼ੋਰ ਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.