SUMMARY OF BENEFITS

Note: The following SUMMARY OF BENEFITS contains the Benefits and applicable Copayments of your medical Plan only. The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of Covered Services and exclusions of the Plan. Your prescription drug benefits are administered by a different plan administrator. For further information, refer to www.UChealthplans.com.

See the end of this SUMMARY OF BENEFITS for important Benefit information.

In-Network Providers: Services by any combination of Anthem Prudent Buyer PPO Providers and Other Health Care Providers

Many words or phrases in this Benefit Booklet have special meanings. Whenever any key terms are shown, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "DEFINITIONS" section starting at page 89.

Health Savings Plan

Member Calendar Year Deductible Responsibility	**Deductible Amount**	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims.	
Calendar Year Deductible Please refer to the Member Deductible in the "Medical Benefit Summary Notes" section for information on how your Calendar Year Deductible works. For additional details about how your non-embedded Deductibles work, please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.	$1,500 Individual / $3,000 family	$2,550 Individual / $5,100 family

* Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the end of this Booklet. Please refer to that section for further details.

Member Calendar Year Out-of-Pocket Responsibility	Out-of-Pocket Amount	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims.	
Calendar Year Out-of-Pocket Maximum When you meet your Out-of-Pocket Maximum amount, you will no longer have to pay the cost shares during the remainder of your Calendar Year. Your Deductible is included in your Out-of-Pocket Maximum. Pharmacy Copayments will apply towards your Out-of-Pocket Maximum, unless otherwise noted. Please refer to the Member Out-of-Pocket Maximum in the "Medical Benefit Summary Notes" section for information on how your Out-of-Pocket Maximum works. For additional details about how non-embedded Out-of-Pocket Maximums work, please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.	$4,000 Individual / $6,400 family	$8,000 Individual / $16,000 family

* Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the end of this Booklet. Please refer to that section for further details.

Member Maximum Lifetime Benefits	Maximum Anthem Payment	
	Services by In-Network Providers	Services by Out-of-Network Providers
Lifetime Benefit Maximum	No maximum	

Note: Please refer to the section Medical Care That Is Covered for additional details regarding your Benefits.

In-Network Providers: Services by any combination of Anthem Prudent Buyer PPO and Other Health Care Providers

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Acupuncture Benefits		
• Acupuncture services – office location The Plan will pay for up to 24 visits per Member during a Calendar Year (visits are combined with "Chiropractic Benefits"). Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. Office visit Benefits will apply to an office visit when billed along with the services. Since your Plan has a Calendar Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Calendar Year Deductible has not been met.	20%	20%
Advanced Imaging Procedure Benefits		
Advanced imaging procedure services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		
• Physician services – office location	20%	40%
• Freestanding facility	20%	40%
• Outpatient Hospital Advanced imaging procedures, when performed by an Out-of-Network Provider, will have a maximum payment of **$210** per visit. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan.	20%	40%