




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.myucship.org](http://www.myucship.org) or by calling 1- 866-940-8306. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1- 866-940-8306 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <u>Network providers</u> : \$100/person or \$200/family. <u>Out-of-network provider</u> : \$200/person or \$400/family.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, <u>network preventive services</u> , <u>emergency room</u> , <u>urgent care</u> , acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and <u>prescription drugs</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. Pediatric dental: \$60/person or \$120/family. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <u>network providers</u> : \$1,500/person or \$3,000/family. For <u>out-of-network providers</u> : \$6,000/person or \$12,000/family. For pediatric dental: \$1,000/person or \$2,000/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, <a href="#">balance-billed</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (866) 940-8306 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes for students and no for dependents.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a <a href="#">health care provider's office or clinic</a>	Primary care visit to treat an injury or illness	No charge at Student Health Services (SHS); \$15 <a href="#">copayment/visit with network provider</a> . <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Specialist</a> visit	No charge at SHS; \$15 <a href="#">copayment/visit with network provider</a> . <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	\$25 <a href="#">copayment</a> for MRI/PET/CT per visit; no charge for ultrasounds, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	You should refer to your policy or <a href="#">plan</a> document for details (*see pages 29, 32, 37, 38, 68 & 77).
If you need	Generic drugs	\$5 <a href="#">copayment</a> at SHS & retail pharmacies/prescription.	\$5 plus any amount over the <a href="#">allowed</a>	Covers up to a 30-day supply of medications

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myucship.org](http://www.myucship.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>drugs to treat your illness or condition</b> More information about <a href="https://myucship.org/uc-davis/coverage/prescription-drugs">prescription drug coverage</a> is available at <a href="https://myucship.org/uc-davis/coverage/prescription-drugs">https://myucship.org/uc-davis/coverage/prescription-drugs</a>		<u>Deductible</u> does not apply.	<u>amount</u> /prescription. <u>Deductible</u> does not apply.	and 180-days for oral contraceptives at retail pharmacies.
	Preferred brand drugs	\$15 <u>copayment</u> at SHS/\$25 <u>copayment</u> at retail pharmacies/prescription. <u>Deductible</u> does not apply.	\$25 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	Covers up to 90 days of medication and up to 180 days of oral contraceptives through Mail Order.
	Non-preferred brand drugs	\$40 <u>copayment</u> at SHS & retail pharmacies/prescription. <u>Deductible</u> does not apply.	\$40 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	<u>Network</u> pharmacies are contracted with OptumRx.
	<a href="#">Specialty drugs</a>	\$40 <u>copayment</u> at SHS & retail pharmacies/prescription. <u>Deductible</u> does not apply.	\$40 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or <u>plan</u> documents for details (*see pages 24, 26, 30, 32, 33, 34, 40, 75 & 77).
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$75 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$75 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	<u>Copayment</u> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge; no <u>deductible</u> .	No Charge; no <u>deductible</u> .	No charge for air ambulance.
	<a href="#">Urgent care</a>	\$25 <u>copayment</u> / visit. No <u>deductible</u> .	40% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> documents for details (*see pages 19, 38, 61, 76, & 88).
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	\$500 copay plus 40% <u>coinsurance</u> after <u>deductible</u> and 25% penalty/per admission	An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or <u>plan</u> documents for details (*see pages 17, 24, 30, 32, 33, 34, 71, 72, 83,

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myucship.org](http://www.myucship.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	& 126) —————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit & <u>provider</u> services: No charge. No <u>deductible</u> . Facility: 20% <u>coinsurance</u>	Office visit & <u>provider</u> services: 40% <u>coinsurance</u> . Facility charges: 40% <u>coinsurance</u> /per admission.	—————none—————
	Inpatient services	20% <u>coinsurance</u>	Facility charges: \$500 <u>copay</u> plus 40% <u>coinsurance</u> plus 25% penalty/per admission. <u>Provider</u> Services: 40% <u>coinsurance</u> .	An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or <u>plan</u> documents for details (*see page 32, 33, 74 & 75).
If you are pregnant	Office visits	No charge, no <u>deductible</u> .	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none————— —
	Childbirth/delivery facility services	20% <u>coinsurance</u>	\$500 copay plus 40% <u>coinsurance</u> after <u>deductible</u> and 25% penalty/per admission	Subject to utilization review for inpatient services beyond 48 hours for vaginal birth and 96 hours for a cesarean birth; waived for emergency admissions. The maximum <u>allowed amount</u> is reduced by 25% for services and supplies provided by a non-contracting hospital.
If you need help recovering or have other special health	<a href="#">Home health care</a>	No charge	40% <u>coinsurance</u>	Subject to utilization review.
	<a href="#">Rehabilitation services</a>	\$20 <u>copayment</u> . No <u>deductible</u> .	40% <u>coinsurance</u>	—————none—————
	<a href="#">Habilitation services</a>	\$20 <u>copayment</u> . No <u>deductible</u> .	40% <u>coinsurance</u>	—————none—————

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myucship.org](http://www.myucship.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>needs</b>	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to utilization review.
	<a href="#">Durable medical equipment</a>	No charge	40% <u>coinsurance</u>	—————none—————
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge. No <u>deductible</u> .	\$0 <u>copayment</u> /visit. No <u>deductible</u> .	\$30 allowance/year for <u>out-of-network providers</u> .
	Children’s glasses	No charge. No <u>deductible</u> .	\$0 <u>copayment</u> /glasses. No <u>deductible</u> .	\$45 frame allowance and \$25 lens allowance/year for <u>out-of-network providers</u> .
	Children’s dental check-up	No charge	No charge	<u>Deductible</u> waived for diagnostic and <u>preventive services</u> .

**Excluded Services & Other Covered Services:**

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- |                       |                         |                            |
|-----------------------|-------------------------|----------------------------|
| • Cosmetic surgery    | • Infertility treatment | • Routine eye care (Adult) |
| • Dental care (Adult) | • Long-term care        |                            |

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)**

- |   |  |   |
|---|--|---|
| • Acupuncture   | • Hearing aids (limited to one hearing aid per ear every four years) | • Routine foot care (if <u>medically necessary</u> )                  |
| • Bariatric surgery (For morbid obesity. Consult your policy or <a href="#">plan</a> document.) | • Non-emergency care when traveling outside of the U.S.              | • Weight loss programs (commercial weight loss programs are excluded) |
| • Chiropractic care   |  | • Private duty nursing  |

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Anthem Blue Cross at 1-866-940-8306 or

Anthem Blue Cross  
 ATTN: Appeals or Grievance  
 P.O. Box 4310  
 Woodland Hills, CA 91367

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Not applicable**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 866-940-8306.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-940-8306.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-940-8306.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-940-8306.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,900</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$570</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$250</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.