




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:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>There is no <a href="#">deductible</a> for UC Family <a href="#">providers</a>. For <a href="#">network providers</a>: \$50/ person or \$400/family; <a href="#">Out-of-network provider</a>: \$500/person or \$1000/family.</p>	<p>Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes, <a href="#">network preventive services</a>, <a href="#">emergency room</a>, <a href="#">urgent care</a>, acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and <a href="#">prescription drugs</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a></p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>Yes. Pediatric dental: \$60/person or \$120/family. There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For UC family <a href="#">providers</a>: \$2,000/person or \$4,000/family.                      For <a href="#">network providers</a>: \$2,000/person or \$6,000/family.                      For <a href="#">out-of-network providers</a>: \$6,000/person or \$12,000/family.                      For pediatric dental: \$1,000/person or \$2,000/family.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>

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
		UC Family Provider (You will pay the least)	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</a> or clinic	Primary care visit to treat an injury or illness	No charge at Carbon Health; \$5 <a href="#">copayment</a> /visit (UC Family). <a href="#">Deductible</a> does not apply.	\$20 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Specialist</a> visit	No charge at Carbon Health; \$10 <a href="#">copayment</a> /visit (UC Family). <a href="#">Deductible</a> does not apply.	\$10 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Preventive care/screening</a> /immunization	No charge. <a href="#">Deductible</a> does not apply.	No charge. <a href="#">Deductible</a> does not apply.	Not covered	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)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	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).

\* For more information about limitation and exceptions, see the [plan](#) or policy document at [www.uocp.edu/ucship](http://www.uocp.edu/ucship).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Family Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://myucship.org/uc-hastings/coverage/prescription-drug-coverage">prescription drug coverage</a> is available at <a href="https://myucship.org/uc-hastings/coverage/prescription-drugs/">https://myucship.org/uc-hastings/coverage/prescription-drugs/</a>	Generic drugs	\$5 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	\$5 <u>copayment</u> at retail pharmacies/prescription. Mail Order \$5 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	\$5 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	Covers up to a 30-day supply of medications and 180-days for oral contraceptives at retail pharmacies.  Covers up to 90 days of medication and up to 180 days of oral contraceptives through Mail Order.  <u>Network</u> pharmacies are contracted with OptumRx.
	Preferred brand drugs	\$25 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	Retail: \$25 <u>copayment</u> /prescription. Mail Order \$25 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	\$25 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	Non-preferred brand drugs	\$40 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	Retail: \$40 <u>copayment</u> /prescription. Mail Order \$40 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	\$40 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	<a href="#">Specialty drugs</a>	\$40 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	Retail: \$40 <u>copayment</u> /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)	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u> + \$150/per admission; 10% <u>coinsurance</u> /per admission at Ambulatory Surgical Facility (ASF).	40% <u>coinsurance</u> + \$250/per admission; 40% <u>coinsurance</u> at ASF.	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 26, 35, 37, 43 & 82).
	Physician/surgeon fees	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u>	40% <u>coinsurance</u>	

\* For more information about limitation and exceptions, see the [plan](#) or policy document at [www.uocp.edu/ucship](http://www.uocp.edu/ucship).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Family Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$125 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$125 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$125 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	<u>Copayment</u> waived if admitted. Member may be responsible for any costs above the <u>allowed amount</u> for an <u>out-of-network provider</u> .
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Applies <u>network deductible</u> . No charge for air ambulance.
	<a href="#">Urgent care</a>	\$25 <u>copayment</u> /visit. No <u>deductible</u> .	\$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 40, 51, & 89).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u> + \$250 <u>copayment</u> /per admission	40% <u>coinsurance</u> + \$500 <u>copayment</u> /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 26, 28, 31, 35, 53, 76, 77, 78 & 80).
	Physician/surgeon fees	10% <u>coinsurance</u> <u>Deductible</u> does not apply.	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$5 <u>copayment</u> /visit; No <u>deductible</u> . Facility charges: 10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Office visit: \$15 <u>copayment</u> /visit. <u>Deductible</u> does not apply. Facility charges: 10% <u>coinsurance</u> + \$150 <u>copayment</u> /per admission <u>Provider Services</u> : 10% <u>coinsurance</u>	Office visit: 40% <u>coinsurance</u> Facility charges: 40% <u>coinsurance</u> + \$250 <u>copayment</u> /per admission <u>Provider Services</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 34, 79, 80 & 82).

\* For more information about limitation and exceptions, see the [plan](#) or policy document at [www.uocp.edu/ucship](http://www.uocp.edu/ucship).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Family Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	10% <u>coinsurance</u> <u>Deductible</u> does not apply.	10% <u>coinsurance</u> + \$250 <u>copayment</u> /per admission <u>Provider Services</u> : 10% <u>coinsurance</u>	40% <u>coinsurance</u> + \$500 <u>copayment</u> /per admission <u>Provider Services</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 34, 35, 79 & 80).
If you are pregnant	Office visits	\$5 <u>copayment</u> /initial visit only. <u>Deductible</u> does not apply.	\$20 <u>copayment</u> /initial visit only. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Copayment</u> applies to initial visit only, thereafter no charge. <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	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Childbirth/delivery facility services	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	10% <u>coinsurance</u> /visit + \$250 <u>copayment</u> /per admission.	40% <u>coinsurance</u> /visit + \$500 <u>copayment</u> /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 needs	<a href="#">Home health care</a>	No charge	No charge	40% <u>coinsurance</u>	Subject to utilization review
	<a href="#">Rehabilitation services</a>	\$10 <u>copayment</u> /visit. No <u>deductible</u>	\$10 <u>copayment</u> /visit. No <u>deductible</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Habilitation services</a>	\$10 <u>copayment</u> /visit. No <u>deductible</u>	\$10 <u>copayment</u> /visit. No <u>deductible</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to utilization review.

\* For more information about limitation and exceptions, see the [plan](#) or policy document at [www.uocp.edu/ucship](http://www.uocp.edu/ucship).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Family Provider (You will pay the least)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	\$0 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$30 allowance/year for <u>out-of-network providers</u> .
	Children’s glasses	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	\$0 <u>copayment</u> /glasses. <u>Deductible</u> does not apply.	\$45 frame allowance and \$25 lens allowance/year for <u>out-of-network providers</u> .
	Children’s dental check-up	No charge	No charge	No charge. <u>Deductible</u> does not apply.	<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](#).)**

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul> |
|---|---|--|

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

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery (For morbid obesity. Consult your policy or <a href="#">plan</a> document.)</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (limited to one hearing aid per ear every four years)</li> <li>• Non-emergency care when traveling outside of the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (if <u>medically necessary</u>)</li> <li>• Weight loss programs (commercial weight loss programs are excluded)</li> <li>• Private duty nursing</li> </ul> |
|---|---|--|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Managed Health Care visit <https://www.dmhc.ca.gov/>, California Department of Insurance, <https://www.insurance.ca.gov/>, Health and Human Services visit [www.hhs.gov](http://www.hhs.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**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 [plan's](#) overall [deductible](#) \$50
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) \$250 + 10%
- Other [coinsurance](#) 10%

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>	\$50
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,840</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$50
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) \$250 + 10%
- Other [coinsurance](#) 10%

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>	\$50
<a href="#">Copayments</a>	\$125
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$435</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$50
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) \$250 + 10%
- Other [coinsurance](#) 10%

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>	\$75
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$185</b>

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