




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 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 or call 1- 866-940-8306 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>network</u> and <u>out-of-network providers</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> .
Are there services covered before you meet your deductible?	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 https://www.healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	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.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> : \$3,000/person or \$6,000/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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.anthem.com/ca or call (866) 940-8306 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge at Student Health Center (SHC); \$15 copayment /visit. Deductible does not apply.	40% coinsurance	—————none—————
	Specialist visit	No charge at SHC; \$20 copayment /visit. Deductible does not apply.	40% coinsurance	—————none—————
	Preventive care/screening/immunization	No charge. Deductible does not apply.	40% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge at SHC; 10% coinsurance .	40% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	You should refer to your policy or plan document for details (*see pages 28, 31, 34, 35 & 64).
If you need drugs to treat your illness or condition More information	Generic drugs	\$5 copayment at retail pharmacies/prescription. Mail Order \$15 copayment /prescription. Deductible does not apply.	\$5 plus any amount over the allowed amount / prescription. Deductible 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

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.ucop.edu/ucship.

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)	
about prescription drug coverage is available at https://myucship.org/uc-merced/coverage/prescription-drugs/	Preferred brand drugs	Retail: \$25 <u>copayment</u> /prescription. Mail Order \$75 <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.	and up to 180 days of oral contraceptives through Mail Order. Network pharmacies are contracted with OptumRx.
	Non-preferred brand drugs	Retail: \$40 <u>copayment</u> / prescription. Mail Order \$120 <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.	
	Specialty drugs	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.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> /per admission at Ambulatory Surgical Facility (ASF).	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 35, 36, 39 & 84).
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	Emergency room care	\$100 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$100 <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> .
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Applies <u>network deductible</u> . No charge for air ambulance.
	Urgent care	\$50 <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 39, 54, & 89).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</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 23, 29, 33, 39, 54, 67,

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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	10% <u>coinsurance</u>	40% <u>coinsurance</u>	68, 72, 73 & 123). —————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$15 <u>copayment</u> /visit. <u>Deductible</u> does not apply. Facility charges: 10% <u>coinsurance</u> per admission <u>Provider Services</u> : 10% <u>coinsurance</u>	Office visit: 40% <u>coinsurance</u> Facility charges: 40% <u>coinsurance</u> + 25% penalty/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 32, 33, 75, 76 & 78).
	Inpatient services	10% <u>coinsurance</u> /per admission	Facility charges: 40% <u>coinsurance</u> + \$500 <u>copayment</u> + 25% penalty/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 33, 33, 75 & 76).
If you are pregnant	Office visits	\$15 <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>	40% <u>coinsurance</u>	—————none—————
	Childbirth/delivery facility services	10% <u>coinsurance</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

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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)	
				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	Home health care	No charge	40% coinsurance	Subject to utilization review
	Rehabilitation services	\$20 <u>copayment</u> /visit. No <u>deductible</u> .	40% <u>coinsurance</u>	—————none—————
	Habilitation services	\$20 <u>copayment</u> /visit. No <u>deductible</u> .	40% <u>coinsurance</u>	—————none—————
	Skilled nursing care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to utilization review.
	Durable medical equipment	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Hospice services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	No charge. No <u>deductible</u> .	\$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. No <u>deductible</u> .	\$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	<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 plan 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 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. 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 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.

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

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	\$200
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$60
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,220

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Joe would pay is	\$750

Mia's Simple Fracture

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$460

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