




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</u> and <u>out-of-network</u> <u>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> .
<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> : \$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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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 <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 <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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 <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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</a> or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit (Graduate); \$17 <u>copay</u> /visit (Undergraduate). <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	—————none—————
	<a href="#">Specialist</a> visit	\$15 <u>copay</u> /visit (Graduate); \$17 <u>copay</u> /visit (Undergraduate). <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <u>coinsurance</u> for blood work, No charge for x-ray	40% <u>coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	No charge	40% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> document for details (*see pages 28, 31, 34, 35, & 64).
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a>	Generic drugs	\$5 <u>copayment</u> /prescription at retail & Student Health Services (SHS) pharmacies. <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 retail medications and up to 180-days for oral contraceptives at retail or SHS pharmacies. <u>Network</u> pharmacies are contracted with OptumRx.
	Preferred brand drugs	\$25 <u>copayment</u> /prescription at retail & SHS pharmacies. <u>Deductible</u> does not apply.	\$25 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	

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)	
is available at <a href="https://myucship.org/uc-riverside/coverage/prescription-drugs/">https://myucship.org/uc-riverside/coverage/prescription-drugs/</a>	Non-preferred brand drugs	\$50 <u>copayment</u> /prescription at retail & SHS pharmacies. <u>Deductible</u> does not apply.	\$50 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	<a href="#">Specialty drugs</a>	\$50 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	\$50 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>	40% <u>coinsurance</u> + 25% penalty	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, 32, 35, 52, 70, 76, 78, 121, & 126).
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$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> .
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No charge for air ambulance.
	<a href="#">Urgent care</a>	\$50 <u>copayment</u> / visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> documents for details (*see pages 19, 39, 62, 77, 89, 91, & 131).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	\$500 <u>copay</u> plus 40% <u>coinsurance</u> plus 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 26, 30, 32, 41, 50, 51, 62, 68, 69, 70, 72, 76, 77, 84, 93, 115, 121, 126, & 130)
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	

\* 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge. <u>Deductible</u> does not apply. Facility charges: 10% <u>coinsurance</u> . <u>Provider Services</u> 10% <u>coinsurance</u>	Office visit: 40% <u>coinsurance</u> Facility charges: 40% <u>coinsurance</u> plus 25% penalty. <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 page 32, 33, 34, 76 & 78).
	Inpatient services	10% <u>coinsurance</u>	Facility Charges: \$500 <u>copay</u> plus 40% <u>coinsurance</u> plus 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 page 32, 34 & 76).
If you are pregnant	Office visits	\$15 <u>copayment</u> /visit (Graduate); \$17 <u>copayment</u> /visit (Undergraduate); initial visit only. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Copayment</u> applies to initial visit only, thereafter no charge services. <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>	\$500 <u>copay</u> plus 40% <u>coinsurance</u> + 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 needs	<a href="#">Home health care</a>	No charge	40% <u>coinsurance</u>	Subject to utilization review.
	<a href="#">Rehabilitation services</a>	\$15 <u>copay</u> /visit (Graduate); \$17 (Undergraduate). <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	—————none—————
	<a href="#">Habilitation services</a>	\$15 <u>copayment</u> / visit (Graduate); \$17 <u>copayment</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)	
		visit (Undergraduate). <u>Deductible</u> does not apply.		
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	\$500 <u>copay</u> plus 40% <u>coinsurance</u> /per admission	Subject to utilization review.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Hospice services</a>	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. 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:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
• Cosmetic surgery	• Infertility treatment	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
• 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 [plan's](#) overall [deductible](#) \$200
- [Specialist copayment](#) \$15 Grad/\$17 UGrad
- 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*)

<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>	\$200
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,060</b>

### 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](#) \$15 Grad/\$17 UGrad
- 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*)

<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>	\$1,300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,400</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$200
- [Specialist copayment](#) \$15 Grad/\$17 UGrad
- 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*)

<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>	\$200
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>

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