




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:
<p>What is the overall deductible?</p>	<p>There is no deductible for UC Family providers. For network providers: \$500/ person or \$1000/family; Out-of-network provider: \$1000/person or \$2000/family.</p>	<p>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes, network preventive services, emergency room, urgent care, acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and prescription drugs.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. Pediatric dental: \$60/person or \$120/family. There are no other specific deductibles.</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For UC family providers: \$2000/person or \$3000/family. network providers: \$2500/person or \$5000/family. For out-of-network providers: \$5000/person or \$7000/family. For prescriptions \$1000/person or \$2000/family. For pediatric dental: \$1000/person or \$2000/family.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
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 for students and no for dependents.	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
		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 health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge Student Health Services (SHS); \$5 copayment/visit (UC Family). Deductible does not apply.	\$20 copayment/visit . Deductible does not apply.	40% coinsurance	—————none—————
	Specialist visit	No charge (SHS); \$10 copayment/visit (UC Family). Deductible does not apply.	\$30 copayment/visit . Deductible does not apply.	40% coinsurance	—————none—————
	Preventive care/screening/immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered	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)	10% coinsurance . Deductible does not apply.	20% coinsurance	40% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	10% coinsurance . Deductible does not apply.	20% coinsurance	40% coinsurance	You should refer to your policy or plan document for details (*see pages 30, 33, 37, 39, & 67).

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

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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://myucship.org/uc-san-diego/coverage/prescription-drugs/	Generic drugs	\$5 <u>copayment</u> (SHS), \$10 <u>copayment</u> (UC Family)/prescription. <u>Deductible</u> does not apply.	\$10 <u>copayment</u> /prescription at retail pharmacies. <u>Deductible</u> does not apply.	\$10 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 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> (SHS), \$40 <u>copay</u> (UC Family) pharmacies/prescription <u>Deductible</u> does not apply.	\$40 <u>copayment</u> /prescription at retail pharmacies. <u>Deductible</u> does not apply.	\$40 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	Non-preferred brand drugs	\$40 <u>copayment</u> (SHS), \$100 <u>copayment</u> (UC Family)/prescription. <u>Deductible</u> does not apply.	\$100 <u>copayment</u> /prescription at retail pharmacies. <u>Deductible</u> does not apply.	\$100 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	Specialty drugs	10% up to a maximum of \$100 <u>copayment</u> /prescription (SHS & UC Family). <u>Deductible</u> does not apply.	10% up to a maximum of \$100 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	10% up to a maximum of \$100 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> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> + \$250 <u>copayment</u> /per admission; 20% <u>coinsurance</u> /per admission at Ambulatory Surgical Center (ASC)	40% <u>coinsurance</u> + \$250 <u>copayment</u> +25% penalty/per admission; 40% <u>coinsurance</u> at ASC.	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 27, 37, 38, 87 & 123).
	Physician/surgeon fees	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	Emergency room care	\$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> .

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

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)	
	Emergency medical transportation	20% <u>coinsurance</u> . Network <u>Deductible</u> applies.	20% <u>coinsurance</u> . Network <u>deductible</u> applies.	20% <u>coinsurance</u> . Network <u>deductible</u> <u>applies</u> .	No charge for air ambulance.
	Urgent care	SHS no charge; UC Family \$25 <u>copayment/visit</u> , <u>Deductible</u> does not apply.	\$50 <u>copayment/visit</u> . <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 18, 19, 20, 21, 42, 58, & 91).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> + \$500 <u>copayment/per</u> admission	40% <u>coinsurance</u> + \$500 <u>copayment</u> + 25% <u>penalty/per</u> 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 25, 27, 32, 45, 53, 70, 72, 73, 75, 86 & 87).
	Physician/surgeon fees	10% <u>coinsurance</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge (SHS)/\$5 <u>copayment</u> (UC Family)/visit. <u>Deductible</u> does not apply. Facility charges: 5% <u>coinsurance</u> . <u>Provider</u> services: 5% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Office visit: \$10 <u>copayment/visit</u> . <u>Deductible</u> does not apply. Facility charges: 20% <u>coinsurance</u> + \$250 <u>copayment/per</u> admission. <u>Provider</u> services: 20% <u>coinsurance</u> .	Office visit: 40% <u>coinsurance</u> . Facility charges: \$250 <u>copayment</u> + 40% <u>coinsurance/per</u> 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 pages 35, 37, 38, 53, 78 & 79).
	Inpatient services	5% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Facility Charges: 5% <u>coinsurance</u> + \$500 <u>copayment/per</u> admission. <u>Provider</u> services: 5% <u>coinsurance</u> . <u>Deductible</u> does not apply.	40% <u>coinsurance</u> + \$500 <u>copayment</u> + 25% <u>penalty/per</u> 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 pages 34, 37, 38, 77 & 78).

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

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 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.	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Childbirth/delivery facility services	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> + \$500 <u>copayment</u> /per admission	40% <u>coinsurance</u> + \$500 <u>copayment</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	Home health care	No charge. <u>Deductible</u> does not apply.	No charge.	40% coinsurance	Subject to utilization review
	Rehabilitation services	Physical Therapy: \$15 & Speech/Occupational Therapy: \$15 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	Physical Therapy: \$15 & Speech/Occupational Therapy: \$30 <u>copayment</u> /visit. <u>Deductible</u> does not apply	40% coinsurance	—————none—————

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)	
	Habilitation services	Physical Therapy: \$15 & Speech/Occupational Therapy: \$15 <u>copayment/visit</u> . <u>Deductible</u> does not apply.	Physical Therapy: \$15 & Speech/Occupational Therapy: \$30 <u>copayment/visit</u> . <u>Deductible</u> does not apply.	40% coinsurance	_____none_____
	Skilled nursing care	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% coinsurance	40% coinsurance	Subject to utilization review.
	Durable medical equipment	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	40% <u>coinsurance</u>	_____none_____
	Hospice services	10% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	40% <u>coinsurance</u>	_____none_____
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	\$0 <u>copayment/visit</u> . <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/glasses</u> . <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"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Routine eye care (Adult)

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

- Acupuncture
- Bariatric surgery (For morbid obesity. Consult your policy or [plan](#) document.)
- Chiropractic care
- Hearing aids (limited to one hearing aid per ear every four years)
- Non-emergency care when traveling outside of the U.S.
- Routine foot care (must be medically necessary)
- Weight loss programs (commercial weight loss programs are excluded)
- 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](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) \$500 + 20%
- Other [coinsurance](#) 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,700

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) \$500 + 20%
- Other [coinsurance](#) 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) \$500 + 20%
- Other [coinsurance](#) 30%

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	\$500
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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