**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 network providers and out-of-network providers: $300 per person or $600 / family. | 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. |
| **Are there services covered before you meet your deductible?** | Yes, network preventive services, emergency room, urgent care, acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and prescription drugs. | 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 |
| **Are there other deductibles for specific services?** | Yes. Pediatric dental: $60/person or $120/family. There are no other specific deductibles. | 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. |
| **What is the out-of-pocket limit for this plan?** | For network providers: $3,000/person or $6,000/family. For out-of-network providers: $6,000/person or $12,000/family. For pediatric dental: $1,000/person or $2,000/family. | 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. |
| **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. |

| 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 for student 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 |
|---|---|---|---|---|
| | | 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); $10 copayment/ visit with network provider. Deductible does not apply. | 40% coinsurance | ——————none—————— |
| | Specialist visit | No charge at SHC; $10 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; Diagnostic lab: 15% coinsurance. | 40% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance. | 40% coinsurance | You should refer to your policy or plan document for details (*see pages 28, 31, 34, 35, 64 & 73). |
| **If you need drugs to treat** | Generic drugs | $5 copayment at SHC; $10 copayment at retail pharmacies/prescription. | $10 plus any amount over the allowed amount / prescription. | Covers up to a 30-day supply of medications and 180-days for oral |



* 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) | |
| **your illness or condition** More information about **prescription drug coverage** is available at https://myucship.org/uc-santa-cruz/coverage/prescription-drugs/ | | Deductible does not apply. | Deductible does not apply. | contraceptives at retail pharmacies. Network pharmacies are contracted with OptumRx. |
| | Preferred brand drugs | $25 copayment at SHC; $40 copayment at retail pharmacies / prescription. Deductible does not apply. | $40 plus any amount over the allowed amount/ prescription. Deductible does not apply. | |
| | Non-preferred brand drugs | $40 copayment at SHC; $60 copayment at retail pharmacies / prescription. Deductible does not apply. | $60 plus any amount over the allowed amount/ prescription. Deductible does not apply. | |
| | Specialty drugs | $60 copayment at SHC; $80 copayment at retail pharmacies / prescription. Deductible does not apply. | $80 plus any amount over the allowed amount/ prescription. Deductible does not apply. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance/per admission at Ambulatory Surgical Facility (ASF). | 40% coinsurance 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 plan documents for details (*see pages 18, 21, 26, 34, 78 & 121). |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | $125 copayment/visit. Deductible does not apply. | $125 copayment/visit. Deductible does not apply. | Copayment waived if admitted. Member may be responsible for any costs above the allowed amount for an out-of-network provider. |
| | Emergency medical transportation | 15% coinsurance | 15% coinsurance | No charge for air ambulance. |
| | Urgent care | $25 copayment/ visit. No deductible. | 40% coinsurance | You should refer to your policy or |

| 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) | |
| | | | | plan documents for details (*see pages 38, 48, 49 & 89). |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance/per admission | 40% coinsurance + $500 copayment/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 plan documents for details (*see pages 24, 28, 29, 49, 50, 52, 54, 67, 68 & 73). |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visit: No charge.<br>Deductible does not apply.<br>Facility charges:<br>15% coinsurance per admission<br>Provider Services: 15% coinsurance | Office visit: 40% coinsurance/visit.<br>Facility charges: 40% coinsurance<br>Provider Services: 40% coinsurance | An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or plan documents for details (*see pages 32, 33, 75, 76 & 78). |
| | Inpatient services | 15% coinsurance/per admission | Facility charges: 40% coinsurance + $500 copayment.<br>Provider Services: 40% coinsurance | An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or plan documents for details (*see pages 32, 33, 75 & 76). |
| **If you are pregnant** | Office visits | $10 copayment, initial visit. Deductible does not apply. | 40% coinsurance | Copayment applies to initial visit only, thereafter no charge. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include |



* 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) | |
| | | | | tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 15% coinsurance | 40% coinsurance | ——————none—————— |
| | Childbirth/delivery facility services | 15% coinsurance/per admission. | 40% coinsurance/visit + $500 copayment / 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 allowed amount 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 | $25 copayment/visit. Deductible does not apply. | 40% coinsurance | ——————none—————— |
| | Habilitation services | $25 copayment/visit. Deductible does not apply. | 40% coinsurance | ——————none—————— |
| | Skilled nursing care | 15% coinsurance | 40% coinsurance | Subject to utilization review. |
| | Durable medical equipment | 15% coinsurance | 40% coinsurance | ——————none—————— |
| | Hospice services | 15% coinsurance | 40% coinsurance | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | No charge. No deductible. | $0 copayment/visit. Deductible does not apply. | $30 allowance/year for out-of-network providers. |
| | Children's glasses | No charge. No deductible. | $0 copayment/glasses. Deductible does not apply. | $45 frame allowance and $25 lens allowance/year for out-of-network providers. |
| | Children's dental check-up | No charge | No charge | Deductible waived for diagnostic and preventive services. |

## 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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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 (if medically necessary)
- Weight loss programs (commercial weight loss programs are excluded)
- 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, kwiijigo 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** | **$300** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $200 |
| Coinsurance | $1,800 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,360** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $200 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$760** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $100 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$700** |

The plan would be responsible for the other costs of these EXAMPLE covered services.