




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?	There is no <u>deductible</u> for UC Family <u>providers</u> . For <u>network providers</u> : \$400/person or \$800/family; <u>Out-of-network provider</u> : \$1,600/person or \$3,200/family.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , 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 plan 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 plan 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 plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For UC family <u>providers</u> : \$8,700/person or \$17,400/family. For <u>network providers</u> : \$8,700/person or \$17,400/family. For <u>out-of-network providers</u> : \$25,000/person or \$50,000/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 plan , 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit ?	Premiums, <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> .
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 <u>network providers</u> .	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</u> charge 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 referral to see a specialist ?	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
		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	\$20 <u>copayment</u> / visit (UC Family). <u>Deductible</u> does not apply.	\$35 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	————none————
	Specialist visit	\$25 <u>copayment</u> / visit (UC Family). <u>Deductible</u> does not apply.	\$50 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	————none————
	Preventive care/screening /immunization	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that are not 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	Diagnostic test (x-ray, blood work)	5% <u>coinsurance</u> for UC Family x-ray and blood work	20% <u>coinsurance</u>	50% <u>coinsurance</u>	————none————
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> document for details (*see pages 30, 33, 38, 40, 69 & 75).
If you need drugs to treat	Generic drugs	\$10 <u>copayment</u> / prescription at retail	\$10 <u>copayment</u> at retail pharmacies/prescription	\$10 plus any amount over the <u>allowed amount</u> /	Covers up to a 30-day supply of medications and 180-days for

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)	
your illness or condition More information about prescription drug coverage is available at https://myucship.org/uc-san-francisco/coverage/prescription-drugs/		pharmacies/prescription. <u>Deductible</u> does not apply.	Mail Order \$30 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	prescription. <u>Deductible</u> does not apply.	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	\$40 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	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.	
	Non-preferred brand drugs	\$75 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	Retail: \$75 <u>copayment</u> /prescription. Mail Order \$225 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	\$75 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	Specialty drugs	10% up to \$250 <u>copayment</u> /prescription at retail pharmacies/prescription. <u>Deductible</u> does not apply.	Retail: 10% up to \$250 <u>copayment</u> /prescription. <u>Deductible</u> does not apply.	10% up to \$250 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)	5% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> at Ambulatory Surgical Facility (ASF).	50% <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 27, 32, 38, 39, 41, 43 & 89).
	Physician/surgeon fees	5% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

* 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
		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	Emergency room care	\$175 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$175 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$175 <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	20% <u>coinsurance</u> .	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Applies <u>network deductible</u> . No charge for air ambulance.
	Urgent care	\$50 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$50 <u>copayment</u> / visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> documents for details (*see pages 44, 57, & 94).
If you have a hospital stay	Facility fee (e.g., hospital room)	5% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	50% <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 25, 32, 36, 59, 73, 77 & 78).
	Physician/surgeon fees	5% <u>coinsurance</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$0 <u>copayment</u> /visit; No <u>deductible</u> . Facility charges: 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. <u>Provider Services</u> : 5% <u>coinsurance</u>	Office visit: \$0 <u>copayment</u> /visit. <u>Deductible</u> does not apply. Facility charges: 20% <u>coinsurance</u> + \$0 <u>copayment</u> /per admission. <u>Deductible</u> does not apply. <u>Provider Services</u> : 20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Office visit: 35% <u>coinsurance</u> . <u>Deductible</u> does not apply. Facility charges: 50% <u>coinsurance</u> + \$250 <u>copayment</u> /per admission. <u>Deductible</u> does not apply. <u>Provider Services</u> : 50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	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, 80, 81 & 83).

* 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
		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	5% <u>coinsurance</u> at Langley Porter Psychiatric Institute and all other UC Medical Center. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> + \$0 <u>copayment</u> /per admission. <u>Deductible</u> does not apply. <u>Provider Services</u> : 20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Facility charges: 50% <u>coinsurance</u> + \$500 <u>copayment</u> + 25% penalty/per admission. <u>Deductible</u> does not apply. <u>Provider Services</u> : 50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	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, 80 & 81).
If you are pregnant	Office visits	\$20 <u>copayment</u> /initial visit only. <u>Deductible</u> does not apply.	\$35 <u>copayment</u> /initial visit only. <u>Deductible</u> does not apply.	50% <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	5% <u>coinsurance</u> at all other UC Medical Center. <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Childbirth/delivery facility services	No charge at UCSF; 5% <u>coinsurance</u> at all other UC Medical Centers.	20% <u>coinsurance</u> /visit + \$0 <u>copayment</u> /per admission.	50% <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	Home health care	No charge. No <u>deductible</u> .	No charge.	50% <u>coinsurance</u>	Subject to utilization review

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)	
have other special health needs	Rehabilitation services	\$10 <u>copayment</u> /visit. No <u>deductible</u> .	\$25 <u>copayment</u> /visit. No deductible.	50% <u>coinsurance</u>	—————none—————
	Habilitation services	\$10 <u>copayment</u> /visit. No <u>deductible</u> .	\$25 <u>copayment</u> /visit. No deductible.	50% <u>coinsurance</u>	—————none—————
	Skilled nursing care	5% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Subject to utilization review.
	Durable medical equipment	5% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Hospice services	5% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <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</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"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (For morbid obesity. Consult your policy or plan document.) • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids (limited to one hearing aid per ear every four years) • Non-emergency care when traveling outside of the U.S. 	<ul style="list-style-type: none"> • Routine foot care (if <u>medically necessary</u>) • 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.dmhca.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	\$400
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	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:

Cost Sharing	
Deductibles	\$400
Copayments	\$150
Coinsurance	\$1,600

What isn't covered	
Limits or exclusions	\$60

The total Peg would pay is	\$2,210
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$400
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	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	\$6,700
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$500
Coinsurance	\$400

What isn't covered	
Limits or exclusions	\$60

The total Joe would pay is	\$1,360
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$400
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$3,700
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$700
Coinsurance	\$120

What isn't covered	
Limits or exclusions	\$0

The total Mia would pay is	\$1,220
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.