Anthem Blue Cross
University of California Student Health Insurance Plan (UC SHIP)
UC Merced

Coverage Period: 2015 – 2016 Benefit Year

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Benefit Booklet at www.ucop.edu/ucship or by calling 1-866-940-8306.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO Providers: **$200**/insured person For Non-PPO Providers: **$200**/insured person Does not apply to services provided at the Student Health Services, Preventive Care, Office Visit Copayments, and Prescription Drugs. PPO Provider and Non-PPO Provider deductibles are combined.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your Benefit Booklet to see when the **deductible** starts over. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$500**/admission for non-PPO hospital or residential treatment center; waived for emergency admission.	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.
Is there an out–of–pocket limit on my expenses?	For PPO Providers: **$3,000** insured person/benefit year For Non-PPO Providers: **$6,000** insured person/benefit year/The maximums for PPO Providers and Non-PPO Providers are separate.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Questions: Call 1-866-940-8306 or visit www.ucop.edu/ucship. **Click to your campus homepage to find the Benefit Booklet.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary, on page 3. You can view the Glossary under Customer Support at http://www.anthem.com/ca or call **1-866-940-8306** to request a copy.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Balance-billed charges and health care premiums, and charges for services not covered under the plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com/ca or call **1-866-940-8306** for a list of Participating providers.	If you use an in-network doctor or *other health care* **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	You need a written **referral** from a primary care physician to see a specialist. There may be some providers or services for which **referrals** are not required. Please see the Benefit Booklet of coverage for details.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your Benefit Booklet for additional information about **excluded services**.

GLOSSARY

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** copayment/ visit	**40%** coinsurance	Deductible waived for PPO providers.
	Specialist visit	**$20** copayment/ visit	**40%** coinsurance	Deductible waived for PPO providers.
	Other practitioner office visit	Chiropractor **$20** copayment/ visit Acupuncture **$20** copayment/ visit	Chiropractor **40%** Coinsurance Acupuncture **40%** Coinsurance	Deductible waived for PPO providers. Acupuncture coverage is limited to a total of 20 visits In-Network and Non-Network Providers combined per Benefit Year.
	Preventive care/screening/ immunization	No Cost Share	**40%** coinsurance	Services are to be provided by your primary care clinician. Deductible waived for PPO providers.

Questions: Call 1-866-940-8306 or visit www.ucop.edu/ucship. Click to your campus homepage to find the Benefit Booklet.
If you aren't clear about any of the underlined terms used in this form, see the Glossary, on page 3. You can view the Glossary under Customer Support at http://www.anthem.com/ca or call **1-866-940-8306** to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	**10%** coinsurance	**40%** coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	**10%** coinsurance	**40%** coinsurance	Services will not be covered if utilization review is not obtained. Costs may vary by site of service. You should refer to your Benefit Booklet for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mycatamaranrx.com**	Generic Drugs	**$5** Copayment/ prescription for retail pharmacies	**$5** plus any amount over the contracted rate	Covers up to a 30 day supply. Not subject to the Deductible. PPO Pharmacies are contracted with Catamaran. Please see www.mycatamaranrx.com for a list of participating pharmacies.
	Brand Drugs	**$25** Copayment/ prescription for retail pharmacies	**$25** plus any amount over the contracted rate	
	Non-Formulary Drugs	**$40** Copayment/ prescription for retail pharmacies	**$40** plus any amount over the contracted rate	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** coinsurance	**40%** coinsurance	——————none——————
	Physician/surgeon fees	**10%** coinsurance	**40%** coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	**$100** Copayment	**$100** Copayment; If admitted, **10%** first 48 hours; **40%** after 48 hours (unless insured person can't be moved safely)	Waived if admitted inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate. Member may be responsible for any costs above the allowed amount for a non-PPO provider.
	Emergency medical transportation	**10%** coinsurance	**10%** coinsurance	No cost for air ambulance.
	Urgent care	**$50** copayment/ visit	**40%** coinsurance	Costs may vary by site of service. You should refer to your Benefit Booklet for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** coinsurance	**40%** coinsurance	**$500**/admission copayment for non-PPO hospital or residential treatment center; waived for emergency admission. Subject to utilization review for inpatient services; waived for emergency admissions.
	Physician/surgeon fee	**10%** coinsurance	**40%** coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit **$15** Copayment/Visit Mental/Behavioral Health Facility Program-Facility Charges **10%** Coinsurance	Mental/Behavioral Health Office Visit **40%** Coinsurance Mental/Behavioral Health Facility Program-Facility Charges **40%** Coinsurance	——————none——————
	Mental/Behavioral health inpatient services	**10%** Coinsurance	**40%** Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance abuse disorder outpatient services	Substance Abuse Office Visit **$15** Copayment/Visit Substance Abuse Facility Program-Facility Charges **10%** Coinsurance	Substance Abuse Office Visit **40%** Coinsurance Substance Abuse Facility Program-Facility Charges **40%** Coinsurance	——————none——————
	Substance abuse disorder inpatient services	**10%** Coinsurance	**40%** Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	**$15** Copayment/visit	**40%** Coinsurance	Copayment applies to initial visit only, thereafter no charge. Deductible waived for PPO providers.
	Delivery and all inpatient services	**10%** Coinsurance	**40%** Coinsurance	**$500**/admission copayment for non-PPO hospital; waived for emergency admission. Subject to utlization review for inpatient services beyond 48 hours for a vaginal birth and 96 hours for a cesarean birth.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Cost Share	**40%** coinsurance	Subject to utilization review. One visit by a home health aide equals four hours or less; not covered while insured person receives hospice care.
	Rehabilitation services	**$20** copayment/ visit	**40%** coinsurance	Costs may vary by site of service. You should refer to your Benefit Booklet for details. Deductible waived for PPO providers.
	Habilitation services	**$20** copayment/ visit	**40%** coinsurance	Costs may vary by site of service. You should refer to your Benefit Booklet for details. Deductible waived for PPO providers.
	Skilled nursing care	**10%** Coinsurance	**40%** Coinsurance	Subject to utilization review.
	Durable medical equipment	**10%** Coinsurance	**40%** Coinsurance	——————none——————
	Hospice service	**10%** Coinsurance	**40%** Coinsurance	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Benefit Booklet for other excluded services.)

- Cosmetic surgery
- Dental care
- Erectile dysfunction medications
- Exams or tests required for participation in an academic, recreational, or employment activity
- Experimental or unnecessary medical treatment
- Infertility diagnosis & treatment
- Intercollegiate sports injuries
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care unless you have been diagnosed with diabetes. Consult your Benefit Booklet
- Services performed without a Student Health referral, except in emergency
- Weight Loss programs
- Work-related conditions covered by Workers Compensation

Other Covered Services (This isn't a complete list. Check your Benefit Booklet for other covered services and your costs for these services.)

- Bariatric surgery (For morbid obesity. Consult your Benefit Booklet of coverage)
- Psycho-educational testing (Lifetime maximum **$3,000**)
- Hearing aids (Coverage is limited to one hearing aid per ear every four years when you use a PPO provider; not covered with non-PPO providers.)
- Most coverage provided outside the United States.
  See www.BCBS.com/bluecardworldwide

Questions: Call 1-866-940-8306 or visit www.ucop.edu/ucship. Click to your campus homepage to find the Benefit Booklet.
If you aren't clear about any of the underlined terms used in this form, see the Glossary, on page 3. You can view the Glossary under Customer Support at http://www.anthem.com/ca or call **1-866-940-8306** to request a copy.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilnį. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilnį.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,100
- **Patient pays:** $1,440

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copayments	$60
Coinsurance	$980
Limits or exclusions	$150
Total	**$1,440**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,230
- **Patient pays:** $1,170

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copayments	$600
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,170**

Questions: Call 1-866-940-8306 or visit www.ucop.edu/ucship. Click to your campus homepage to find the Benefit Booklet.
If you aren't clear about any of the underlined terms used in this form, see the Glossary, on page 3. You can view the Glossary under Customer Support at http://www.anthem.com/ca or call **1-866-940-8306** to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-940-8306 or visit www.ucop.edu/ucship. Click to your campus homepage to find the Benefit Booklet.
If you aren't clear about any of the underlined terms used in this form, see the Glossary, on page 3. You can view the Glossary under Customer Support at http://www.anthem.com/ca or call **1-866-940-8306** to request a copy.