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

UC Santa Cruz Students and Covered Dependents

Coverage for: Student/Family | **Plan Type:** PPO

The Summary of Benefits 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.ucop.edu/ucship/plan-documents/ 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network and out-of-network providers: $300/ 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.
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
		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 SHS; $25 copayment/visit with network provider. Deductible does not apply.	40% coinsurance	——————none——————
	Specialist visit	No charge at SHS; $25 copayment/visit with network provider. 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 aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
f you have a test	Diagnostic test (x-ray, blood work)	No charge at SHS; 15% coinsurance at network provider	40% coinsurance	——————none——————

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	You should refer to your policy or plan document for details (*see pages 27, 30, 33, 34, & 62).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ucop.edu/ucship/plan-documents/	Generic drugs	$5 copayment at SHS; $10 copayment at retail pharmacies/prescription. Deductible does not apply.	$10 plus any amount over the allowed amount/prescription. Deductible does not apply.	Covers up to a 30-day supply of medications and up to 180-days for oral contraceptives at retail pharmacies. Network pharmacies are contracted with OptumRx.
	Preferred brand drugs	$25 copayment at SHS; $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 copay at SHS; $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 SHS; $80 copayment at retail pharmacies/prescription. Deductible does not apply.	$80 plus any amount over the allowed amount/prescription. Deductible does not apply.	

*For more information about limitations and exceptions, see plan or policy document at www.ucop.edu/ucship.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	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 33, 34, 39 & 82).
	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; no deductible	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 plan documents for details (*see pages 37, 50, & 86).
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	$500 copayment plus 40% coinsurance/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 23, 27, 28, 35, 48, 65, 71, 73, & 90).

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	15% coinsurance	40% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $20 copayment/visit. No deductible. Facility charges: 15% coinsurance	Office visit: 40% coinsurance Facility charges: 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 page 31, 32, 37, 73 & 74).
	Inpatient services	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 page 31, 32, 37, 73 & 74).
If you are pregnant	Office visits	$25 copayment, initial visit only. No deductible.	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 tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	——————none——————

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	15% coinsurance	$500 copayment plus 40% coinsurance/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	0% coinsurance	40% coinsurance	Subject to utilization review.
	Rehabilitation services	$25 copayment/ visit. No deductible.	40% coinsurance	——————none——————
	Habilitation services	$25 copayment/ visit. No deductible.	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	$30 allowance/year for out-of-network providers.
	Children's glasses	No charge, no deductible	$0 copayment/glasses	$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.

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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
- Private-duty nursing
- 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)

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 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? Yes.

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.

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

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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 our 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 network pre-natal care and a hospital delivery)

▪ **The plan's overall deductible**	$300
▪ **Specialist copayment**	$25
▪ **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 **$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$30
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,690

Managing Joe's Type 2 Diabetes

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

▪ **The plan's overall deductible**	$300
▪ **Specialist copayment**	$25
▪ **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 **$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,000
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,660

Mia's Simple Fracture

(network emergency room visit and follow up care)

▪ **The plan's overall deductible**	$300
▪ **Specialist copayment**	$25
▪ **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 **$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$500

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