

## 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/](http://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](http://www.healthcare.gov/sbc-glossary) or call 1- 866-940-8306 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For <u>network</u> and <u>out-of-network providers</u> : \$300/ person or \$600/family.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes, <u>network preventive services</u> , emergency room, <u>urgent care</u> , acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and <u>prescription drugs</u> .	This <u>plan</u> 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 <u>plan</u> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	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 <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network providers</u> : \$3,000/person or \$6,000/family. For <u>out-of-network providers</u> : \$6,000/person or \$12,000/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 <u>plan</u> , 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <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> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge at Student Health Center (SHC); \$10 <u>copayment</u> /visit with <u>network provider</u> . <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	—————none—————
	<u>Specialist</u> visit	No charge at SHC; \$10 <u>copayment</u> /visit with <u>network provider</u> . <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	—————none—————
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	You may have to pay for services that aren't 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	<u>Diagnostic test</u> (x-ray, blood work)	SHC: 15% coinsurance. In-network provider: \$300.00 deductible then 15% co-insurance, once deductible is met.	40% <u>coinsurance</u>	—————none—————

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)	
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> document for details (*see pages 28, 31, 34, 35, 64 & 73).
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.ucop.edu/ucship/plan-documents/">www.ucop.edu/ucship/plan-documents/</a>	Generic drugs	\$5 <u>copayment</u> at SHC; \$10 <u>copayment</u> at retail pharmacies/prescription. <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 pharmacies. <u>Network</u> pharmacies are contracted with OptumRx.
	Preferred brand drugs	\$25 <u>copayment</u> at SHC; \$40 <u>copayment</u> at retail pharmacies/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	\$40 copay at SHC; \$60 <u>copayment</u> at retail pharmacies/prescription. <u>Deductible</u> does not apply.	\$60 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
	<u>Specialty drugs</u>	\$60 <u>copayment</u> at SHC; \$80 <u>copayment</u> at retail pharmacies/prescription. <u>Deductible</u> does not apply.	\$80 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	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 18, 21, 26, 34, 78 & 121).

\*For more information about limitations and exceptions, see plan or policy document at [www.ucop.edu/ucship](http://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)	
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$125 <u>copayment</u> /visit; no <u>deductible</u>	<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> .
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	No charge for air ambulance.
	<u>Urgent care</u>	\$25 <u>copayment</u> / visit. No <u>deductible</u> .	40% <u>coinsurance</u>	You should refer to your policy or <u>plan</u> documents for details (*see pages 38, 48, 49 & 89).
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	\$500 <u>copayment</u> plus 40% <u>coinsurance</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 24, 28, 29, 49, 50, 52, 54, 67, 68 & 73).
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————

\*For more information about limitations and exceptions, see plan or policy document at [www.ucop.edu/ucship](http://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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visit: \$10 <u>copayment</u> /visit. No <u>deductible</u> . Facility charges: 15% <u>coinsurance</u> . Provider Services 15% <u>coinsurance</u>	Office visit: 40% <u>coinsurance</u> Facility charges: 40% <u>coinsurance</u> . Provider 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 page 32, 33, 75, 76 & 78).
	Inpatient services	15% <u>coinsurance</u> /per admission	40% <u>coinsurance</u> + \$500 <u>copayment</u> /per admission. Provider 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 page 32, 33, 75, & 76).
<b>If you are pregnant</b>	Office visits	\$10 <u>copayment</u> , initial visit only. No <u>deductible</u> .	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	15% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Childbirth/delivery facility services	15% <u>coinsurance</u>	\$500 <u>copayment</u> plus 40% <u>coinsurance</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.

\*For more information about limitations and exceptions, see plan or policy document at [www.ucop.edu/ucship](http://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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to utilization review.
	<u>Rehabilitation services</u>	\$25 <u>copayment</u> / visit. No <u>deductible</u> .	40% <u>coinsurance</u>	—————none—————
	<u>Habilitation services</u>	\$25 <u>copayment</u> / visit. No <u>deductible</u> .	40% <u>coinsurance</u>	—————none—————
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to utilization review.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<u>Hospice services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge, no <u>deductible</u>	\$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, no <u>deductible</u>	\$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	<u>Deductible</u> waived for diagnostic and <u>preventive services</u> .

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery (For morbid obesity. Consult your policy or <u>plan</u> document)</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (limited to one hearing aid per ear every four years)</li><li>• Non-emergency care when traveling outside of the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care (if <u>medically necessary</u>)</li><li>• Weight loss programs (commercial weight loss programs are excluded)</li></ul>

**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, kwijjigo holne' 866-940-8306.

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

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 network pre-natal care and a hospital delivery)

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

**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%

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- **Specialist copayment** \$25
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- **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)

**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)

**This EXAMPLE event includes services like:**  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	<b>\$12,800</b>
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<b>Total Example Cost</b>	<b>\$7,400</b>
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<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Peg would pay:**

**In this example, Joe would pay:**

**In this example, Mia would pay:**

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

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

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

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