




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> : \$300/ person or \$600/family; <u>Out-of-network provider</u> : \$500/person or \$1000/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> . |
| 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 <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 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 <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For UC family <u>providers</u> : \$2,000/person or \$4,000/family <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. |

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| 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 |
|--|--|---|---|---|---|
| | | 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 | \$5 copayment /visit. Deductible does not apply. | \$10 copayment /visit. Deductible does not apply. | 40% coinsurance | —————none————— |
| | Specialist visit | \$15 copayment /visit. Deductible does not apply. | \$25 copayment /visit. Deductible does not apply. | 40% coinsurance | —————none————— |
| | Preventive care/screening/immunization | No charge. Deductible does not apply. | No charge. Deductible does not apply. | Not covered | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | 5% coinsurance . Deductible does not apply. | 10% coinsurance | 40% coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 5% coinsurance . Deductible does not apply. | 10% coinsurance | 40% coinsurance | You should refer to your policy or plan document for details (*see pages 29, 32, 36, 38, & 67). |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myucship.org.

| 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 drugs to treat your illness or condition More information about prescription drug coverage is available at https://myucship.org/uc-irvine/prescription-drugs | Generic drugs | \$5 <u>copayment</u> /prescription (Student Health Center -SHC); \$10 <u>copayment</u> /prescription (UC Family). <u>Deductible</u> does not apply. | \$10 <u>copayment</u> /prescription at retail pharmacies. <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 or SHS pharmacies <u>Network</u> pharmacies are contracted with OptumRx. |
| | Preferred brand drugs | \$25 <u>copayment</u> /prescription (SHC); \$35 <u>copayment</u> /prescription (UC Family). <u>Deductible</u> does not apply. | \$35 <u>copayment</u> /prescription at retail pharmacies. <u>Deductible</u> does not apply. | \$35 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply. | |
| | Non-preferred brand drugs | \$40 <u>copayment</u> /prescription (SHC); \$50 <u>copayment</u> /prescription (UC Family). <u>Deductible</u> does not apply. | \$50 <u>copayment</u> /prescription at retail pharmacies. <u>Deductible</u> does not apply. | \$50 plus any amount over the <u>allowed amount</u> /prescription. <u>Deductible</u> does not apply. | |
| | Specialty drugs | \$40 <u>copayment</u> /prescription (SHC); \$50 copay/prescription (UC Family). <u>Deductible</u> does not apply. | \$50 <u>copayment</u> /prescription at retail pharmacies. <u>Deductible</u> does not apply. | \$50 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. | 10% <u>coinsurance</u> + \$250/per admission; Ambulatory Surgery Center (ASC): 10% <u>coinsurance</u> /per admission | 40% <u>coinsurance</u> /per admission; ASC: 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, 26, 32, 35, 36, 37, 38, 44, 65, 79 & 80). |
| | Physician/surgeon | 5% <u>coinsurance</u> . | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myucship.org.

| 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) | |
| | fees | <u>Deductible</u> does not apply. | | | |
| If you need immediate medical attention | Emergency room care | \$125 <u>copayment</u> /visit. <u>Deductible</u> does not apply. | \$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> . |
| | Emergency medical transportation | 10% <u>coinsurance</u> . Network <u>deductible</u> applies. | 10% <u>coinsurance</u> , Network <u>deductible</u> applies | 10% <u>coinsurance</u> ; Network <u>deductible</u> applies | No charge for air ambulance. |
| | Urgent care | \$25 <u>copayment</u> / visit. <u>Deductible</u> does not apply. | \$25 <u>copayment</u> /visit. <u>Deductible</u> does not apply. | 40% <u>coinsurance</u> | You should refer to your policy or <u>plan</u> documents for details (*see pages 19, 42, 65, 92 & 94). |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | \$500 <u>copayment</u> + 10% <u>coinsurance</u> /per admission | \$500 <u>copayment</u> + 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, 26, 31, 32, 34, 35, 44, 53, 54, 65, 71, 75, 78 & 87). |
| | Physician/surgeon fees | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | —————none————— |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit & <u>provider</u> services: No charge. <u>Deductible</u> does not apply. Facility: 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | Office visit & <u>provider</u> services: No charge. <u>Deductible</u> does not apply. Facility charges: 10% <u>coinsurance</u> + \$250 <u>Copayment</u> /per admission. | Office visit: 40% <u>coinsurance</u> Facility charges: 40% <u>coinsurance</u> + 25% penalty/per admission. <u>Provider</u> 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 pages 24, 35, 77 & 78). |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myucship.org.

| 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> . <u>Deductible</u> does not apply. | Facility Charges: 10% <u>coinsurance</u> + \$500 <u>copayment</u> /per admission. <u>Provider services</u> : 10% <u>coinsurance</u> . | Facility charges: 40% <u>coinsurance</u> + \$500 <u>copayment</u> + 25% penalty/per admission. <u>Provider services</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 24, 34, 35, 36, 38, 77 & 78). |
| If you are pregnant | Office visits | \$10 <u>copayment</u> /visit; initial visit only. <u>Deductible</u> does not apply. | \$15 <u>copayment</u> /visit; initial visit only. <u>Deductible</u> does not apply. | 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 | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | —————none————— |
| | Childbirth/delivery facility services | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 10% <u>coinsurance</u> + \$500 <u>copayment</u> /per admission | 40% <u>coinsurance</u> + \$500 <u>copayment</u> + 25% penalty/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. An additional 25% penalty is assessed 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. <u>Deductible</u> does not apply. | No charge | 40% <u>coinsurance</u> | Subject to utilization review. |
| | Rehabilitation services | \$20 <u>copayment</u> /visit. <u>Deductible</u> does not apply. | \$30 <u>copayment</u> /visit. <u>Deductible</u> does not apply. | 40% <u>coinsurance</u> | —————none————— |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myucship.org.

| 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) | |
| | Habilitation services | \$20 <u>copayment</u> /visit. <u>Deductible</u> does not apply. | \$30 <u>copayment</u> /visit. <u>Deductible</u> does not apply. | 40% <u>coinsurance</u> | —————none————— |
| | Skilled nursing care | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | Subject to utilization review. |
| | Durable medical equipment | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 10% <u>coinsurance</u> | 40% <u>coinsurance</u> | —————none————— |
| | Hospice services | 5% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 10% <u>coinsurance</u> | 40% <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.)

- 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 (must be medically necessary)
- Weight loss programs (commercial weight loss programs are excluded)
- Private duty nursing

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.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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](#) \$15
- Hospital (facility) [coinsurance](#) \$500 + 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Copayments | \$500 |
| Coinsurance | \$600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$1,400 |

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](#) \$25
- Hospital (facility) [coinsurance](#) \$500 + 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$100 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$600 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) \$500 + 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$300 |
| Copayments | \$300 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| 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.