Anthem Blue Cross: University of California Student Health Insurance Plan (UC SHIP)
UC Merced Students and Covered Dependents

Coverage Period begins on or after 08/01/2017

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

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.gove/sbc-glossary.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network and out-of-network providers: **$200**/ person or **$400**/family. The **deductible** will not apply to network preventive services, physician office visits, rehabilitation or habilitation; network and out-of-network emergency or urgent care, medical evacuation, repatriation or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes, in-network preventive services, emergency room, urgent care, acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and prescription drugs	This plan covers some services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Pediatric dental: **$60**/person or **$120**/family	You must pay all 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 of this plan?	Yes. 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 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.
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**.

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

Will you pay less if you use a network provider	Yes. See www.anthem.com/ca or call 1-866-940-8306 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)..
Do I need a referral to see a specialist?	Yes. Students contact the Student Health Services (SHS). Dependents call 866-940-8306 for a list of network providers.	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission 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)	Our-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; $15 copayment/visit with network provider	40% coinsurance	Deductible waived for network providers. 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.
	Specialist visit	No charge at SHS; $20 copayment/visit with network provider	40% coinsurance	Deductible waived for network providers.
	Preventive care/screening/ Immunization	No charge	40% coinsurance	Deductible waived for network providers.
If you have a test	Diagnostic test (x-ray, blood work)	No charge at SHS; 10% coinsurance at network provider	40% coinsurance	————————none————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Our-of-Network Provider (you will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% coinsurance at network provider	40% coinsurance	Costs may vary by site of service. You should refer to your policy or plan document for details.
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 copay at retail pharmacies/prescription	$5 plus any amount over the allowed amount/prescription	Covers up to a 30 day supply for retail pharmacies and a 90 day supply for mail order. Not subject to the **deductible**. Network Pharmacies are contracted with OptumRx.
	Preferred brand drugs	Retail: $25 copay/prescription Mail Order $75 copay/prescription	$25 plus any amount over the allowed amount/prescription	
	Non-preferred brand drugs	Retail: $40 copay/prescription Mail Order $120 copay/prescription	$40 plus any amount over the allowed amount/prescription	
	Specialty drugs	Retail: $25 copay/prescription Mail Order $75 copay/prescription	$25 plus any amount over the allowed amount/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Certain surgeries are subject to utilization review. Services not covered if not medically necessary.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	————————none————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Our-of-Network Provider (you will pay the most)	
If you need immediate medical attention	Emergency room services	$100 copayment/visit	$100 copayment/visit	Copayment waived if admitted; **deductible** waived for network and out-of-network **providers**. Member may be responsible for any costs above the **allowed amount** for an out-of-network **provider**.
	Emergency medical transportation	10% coinsurance	10% coinsurance	No charge for air ambulance.
	Urgent care	$50 copayment/ visit	40% coinsurance	**Deductible** waived for network **providers**. You should refer to your policy or plan documents for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$500 copay plus 40% coinsurance/visit	Subject to utilization review for inpatient and certain outpatient services at all facilities, except for emergency admissions. Services not covered if not medically necessary. The maximum **allowed amount** is reduced by 25% for services and supplies provided by a non-contracting hospital.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Our-of-Network Provider (you will pay the most)	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $15 copay/visit Facility charges: 10% coinsurance	Office visit: 40% coinsurance Facility charges: 40% coinsurance	——————none——————
	Inpatient services	10% coinsurance	40% coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Office visit	$15 copay, initial visit only	40% coinsurance	Copayment applies to initial visit only, thereafter no charge. **Deductible** waived for network **providers**.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	——————none——————
	Childbirth/delivery facility services	10% coinsurance	$500 copay plus 40% coinsurance/visit	Subject to utilization review for inpatient services beyond 48 hours for vaginal birth and 96 hours for a cesarean birth; waived for emergency admissions. Services not covered if not medically necessary.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Our-of-Network Provider (you will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	Subject to utilization review. Services not covered if not medically necessary.
	Rehabilitation services	$20 copayment/ visit	40% coinsurance	——————none——————
	Habilitation services	$20 copayment/ visit	40% coinsurance	——————none——————
	Skilled nursing care	10% coinsurance	40% coinsurance	Subject to utilization review. Services not covered if not medically necessary.
	Durable medical equipment	10% coinsurance	40% coinsurance	——————none——————
	Hospice service	10% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	No charge	$0 copay/visit	$30 allowance/year for out-of-network **providers**.
	Children's glasses	No charge	$0 copay/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.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Private-duty nursing • Routine eye care (Adult)	• Routine foot care (unless you have been diagnosed with diabetes) • Weight loss programs
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.

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 claims, 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

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.

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 in-network pre-natal care and a hospital delivery)	
▪ The plan's overall deductible	$200
▪ Specialist (cost sharing)	$20
▪ Hospital (facility) [cost sharing]	10%
▪ Other [cost sharing]	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	$12,731
In this example, Peg would pay:	
Deductibles	$200
Copayments	$60
Coinsurance	$970
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1230

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
▪ The plan's overall deductible	$200
▪ Specialist (cost sharing)	$20
▪ Hospital (facility) [cost sharing]	10%
▪ Other [cost sharing]	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	$7,389
In this example, Joe would pay:	
Deductibles	$200
Copayments	$400
Coinsurance	$1500
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	$2100

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
▪ The plan's overall deductible	$200
▪ Specialist (cost sharing)	$20
▪ Hospital (facility) [cost sharing]	10%
▪ Other [cost sharing]	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	$1,925
In this example, Mia would pay:	
Deductibles	$200
Copayments	$140
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$400