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

Coverage Period begins on or after 08/01/2016

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

Coverage for: Student/Family | **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 policy or plan document at www.ucop.edu/ucship/plan-documents/ or by calling 1-866-940-8306.

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, prescription drugs, physician office visits, rehabilitation, habilitation, network and out-of-network emergency or urgent care, and medical evacuation or repatriation.	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 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.
Is there an out–of–pocket limit on my expenses?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 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. Students contact the Student Health Services (SHS). Dependents call 866-940-8306 for a list of network 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 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-866-940-8306 or visit us at www.ucop.edu/ucship.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-866-940-8306 to request a copy.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out-of-network 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 network **providers**.
	Specialist visit	$20 copayment/ visit	40% coinsurance	**Deductible** waived for network **providers**.
	Other practitioner office visit	Chiropractor & acupuncture $20 copayment/ visit	Chiropractor & acupuncture 40% coinsurance	**Deductible** waived for network **providers**.
	Preventive care/screening/ immunization	No charge	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Costs may vary by site of service. You should refer to your policy or plan document for details. Network and out-of-network **provider** services will not be covered if utilization review is not obtained
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	Retail: $5 copay/prescription Mail Order: $15 copay/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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Certain surgeries are subject to utilization review.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	————————none————————
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**.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
	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. 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——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: $15 copayment Facility charges: 10% coinsurance	Office visit: 40% coinsurance 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 use disorder outpatient services	Office visit: $15 copayment Facility charges: 10% coinsurance	Office visit: 40% coinsurance Facility charges: 40% coinsurance	——————none——————
	Substance use disorder 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	Prenatal and postnatal care	$15 copayment/visit	40% coinsurance	Copayment applies to initial visit only, thereafter no charge. **Deductible** waived for network **providers**.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient 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.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	$20 copayment/ visit	40% coinsurance	——————none——————
	Habilitation services	$20 copayment/ visit	40% coinsurance	——————none——————
	Skilled nursing care	10% coinsurance	40% coinsurance	——————none——————
	Durable medical equipment	10% coinsurance	40% coinsurance	——————none——————
	Hospice service	10% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	$0 copay/visit	$30 allowance/year for out-of-network **providers**
	Glasses	No charge	$0 copay/glasses	$45 frame allowance and $25 lens allowance/year for out-of-network **providers**
	Dental check-up	No charge	No charge	**Deductible** waived for diagnostic and preventive services.

Excluded Services & Other Covered Services:

Services Your Plan 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 (except when prescribed for diabetes)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- 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:

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
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

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.

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:** $6,740
- **Patient pays:** $800

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	$200
Copays	$100
Coinsurance	$500
Limits or exclusions	$0
Total	**$800**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,800
- **Patient pays:** $600

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	$200
Copays	$200
Coinsurance	$200
Limits or exclusions	$0
Total	**$600**

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 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.