# Anthem Blue Cross
# University of California Student Health Insurance Plan (UC SHIP)
# Dependent Medical, Behavioral Health and Pharmacy Plan

**Coverage Period: 08/01/2015-07/31/2016**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Dependent **Plan Type:** Custom EPO

**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 providers: **$400**/member. Does not apply to preventive care, emergency care, urgent care 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 other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For network providers: **$6,000/**member, up to **$13,200** for a 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 does not 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. |
| **Does this plan use a network of providers?** | Yes. | 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**. |
| **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 5. See your policy or plan document for additional information about **excluded services**. |

**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.

- **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 percentage 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 an 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 | 20% coinsurance | Not covered | Services must be performed by an Anthem PPO **provider.** |
| | Specialist visit | 20% coinsurance | Not covered | Services must be performed by an Anthem PPO **provider.** |
| | Other practitioner office visit | Chiropractor & acupuncture 20% coinsurance/visit | Not covered | ----------none---------- |
| | Preventive care/screening/ immunization | No charge | Not covered | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not covered | ----------none---------- |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | Costs may vary by site of service. You should refer to your policy or plan document for details. **Provider** services will not be covered if utilization review is not obtained. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.ucop.edu/ucship/plan-documents/ | Generic drugs | $5 copay (retail), $15 copay (mail order)/prescription | Not covered | Covers up to a 30 day supply for retail and 90 day supply for mail order. Not subject to the **deductible**. Network pharmacies are contracted with OptumRx (formerly Catamaran) |
| | Brand drugs | 30% of negotiated fees | Not covered | |
| | Non-Formulary drugs | 30% of negotiated fees | Not covered | |
| **If you have outpatient surgery** | Facility fee(e.g., ambulatory surgery center) | 20% coinsurance | Not covered | Certain surgeries are subject to utilization review. |
| | Physician/surgeon fee | 20% coinsurance | Not covered | ----------none---------- |
| **If you need immediate medical attention** | Emergency room services | $100 copayment plus 20% coinsurance/visit | $100 copayment plus 20% coinsurance/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 | 20% coinsurance | 20% coinsurance | The percentage of coverage is based on billed charges. |
| | Urgent care | $50 copayment plus 20% coinsurance/visit | Not covered | Costs may vary by site of service. You should refer to your policy or plan document for details. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee(e.g., hospital room) | 20% coinsurance | Not covered | Subject to utilization review for inpatient services; waived for emergency admissions. The maximum allowed amount is reduced by 25% for services and supplies provided by a non-contracting hospital. |
| | Physician/surgeon fee | 20% coinsurance | Not covered | Prior authorization from Anthem Blue Cross is required |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% coinsurance | Not covered | ----------none---------- |
| | Mental/Behavioral health inpatient services | 20% coinsurance | Not covered | Prior authorization from Anthem Blue Cross is required |
| | Substance use disorder outpatient services | 20% coinsurance | Not covered | ----------none---------- |
| | Substance use disorder inpatient services | 20% coinsurance | Not covered | Prior authorization from Anthem Blue Cross is required |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | Not covered | Copayment applies to first visit only; thereafter no charge. |
| | Delivery and all inpatient services | 20% coinsurance | Not covered | Prior authorization from Anthem Blue Cross is required. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | Subject to utilization review. One visit by a home health aide equals four hours or less; not covered while person receives hospice care. |
| | Rehabilitation services | 20% coinsurance | Not covered | ----------none---------- |
| | Habilitation services | 20% coinsurance | Not covered | ----------none---------- |
| | Skilled nursing care | 20% coinsurance | Not covered | Subject to utilization review. |
| | Durable medical equipment | 20% coinsurance | Not covered | ----------none---------- |
| | Hospice service | 20% coinsurance | Not covered | Bereavement counseling limited to 4 visits in 12 months. |
| **If your child needs dental or eye care** | Eye exam | $10 copay/visit | $0 copay/visit | $49 allowance/year for out-of-network **providers** |
| | Glasses | $25 copay/pair of lenses | $0 copay/pair of lenses | $35 allowance/year for out-of-network **providers** |
| | Dental check-up | No charge | 20% coinsurance | $25 **deductible** for network **providers**, $50 **deductible** for out-of-network **providers**. 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 BlueCross
ATTN: Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

## 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.**

## 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** $6,640
- **Patient pays** $900

**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 | $0 |
| Coinsurance | $700 |
| Limits or exclusions | $0 |
| **Total** | **$900** |

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

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

**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 | $0 |
| Coinsurance | $600 |
| Limits or exclusions | $0 |
| **Total** | **$800** |

# 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.