

Anthem Blue Cross: University of California Student Health Insurance Plan (UC SHIP)

UC San Francisco 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 <u>deductible</u>?	For UC Family providers: \$0 /person. For network providers: \$200 /person or \$400 /family. For out-of-network providers: \$750 /person or \$1,500 /family. The deductible will not apply to network preventive services, prescription drugs, physician office visits, rehabilitation, and habilitation, network or out-of-network emergency or urgent care, mental health/substance use disorder, 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 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes. For UC Family providers: \$2,000 /person or \$4,000 /family. 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 <u>out-of-pocket limit</u>?	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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. Students contact Student Health and Counseling Services (SHCS). 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

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		different kinds of providers .
Do I need a referral to see a specialist ?	Yes. Student and adult dependents contact SHCS. Dependent children 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 .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. 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 UC Family Provider	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	No charge at SHCS; \$25 copay/visit	\$25 copay/ visit	40% coinsurance	Deductible waived for network providers .
	Specialist visit	\$10 copay/visit	\$40 copay/visit	40% coinsurance	Deductible waived for network providers .
	Other practitioner office visit	Chiropractor & acupuncture \$10 copay/visit	Chiropractor & acupuncture \$25 copay/visit	Chiropractor & acupuncture 40% coinsurance	Deductible waived for network providers .

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	Preventive care/ screening/ immunization	No charge	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	No charge at SHCS for blood work; 5% coinsurance for UC Family x-ray and blood work	10% coinsurance	40% coinsurance	No cost share for x-ray and lab services performed for a preventive exam.
	Imaging (CT/PET scans, MRIs)	5% coinsurance	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.

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<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.ucop.edu/ucship/plan-documents/.</p>	Generic Drugs	Not covered	Retail: \$5 copay/ prescription Mail Order: \$15 copay/ prescription	\$5 copay/ prescription plus any amount over the allowed amount.	Covers up to a 30 day supply for retail pharmacies and a 90 day supply for mail order. Not subject to the <u>deductible</u> . Network pharmacies are contracted with OptumRx.
	Preferred Brand Drugs	Not covered	Retail: \$25 copay/ prescription Mail Order: \$75 copay/ prescription	\$25 copay/ prescription plus any amount over the allowed amount	
	Non-Preferred Brand Drugs	Not covered	Retail: \$40 copay/ prescription Mail Order: \$120 copay/ prescription	\$40 copay/ prescription plus any amount over the allowed amount	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	\$250 plus 10% coinsurance/visit	\$250 plus 40% coinsurance/visit	Certain surgeries are subject to utilization review for network and out-of-network facilities.
	Physician/surgeon fees	5% coinsurance	10% coinsurance	40% coinsurance	-----none-----
<p>If you need immediate medical attention</p>	Emergency room services	\$125 copay/visit	\$125 copay/visit	\$125 copay/visit	Copayment waived if admitted; <u>deductible</u> waived for network and out-of-network <u>providers</u> . Member may be responsible for any costs above the <u>allowed amount</u> for an out-of-network <u>provider</u> .

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	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	No cost for air ambulance.
	Urgent care	\$25 copay/ visit	\$25 copay/ visit	40% coinsurance	<u>Deductible</u> waived for network <u>providers</u> . You should refer to your policy or plan document for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge at UCSF; 5% coinsurance at Langley Porter Psychiatric Institute and all other UC Medical Centers	\$250 plus 10% coinsurance/visit	\$500 plus 40% coinsurance/visit	Subject to utilization review for inpatient and certain outpatient services at all facilities, except for emergency admissions. The maximum allowed amount is reduced by 25% for services and supplies provided by a non-contracting hospital.
	Physician/surgeon fee	No charge at UCSF; 5% coinsurance at Langley Porter Psychiatric Institute and all other UC Medical Centers	10% coinsurance	40% coinsurance	-----none-----

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: No charge at SHCS; \$5 copay/visit Facility charges: 5% coinsurance	Office visit: \$15 copay/visit Facility charges \$250 plus 10% coinsurance/visit	Office visit 35% coinsurance Facility charges: \$250 plus 40% coinsurance/visit	Deductible waived for network and out-of-network provider physician outpatient visits.
	Mental/Behavioral health inpatient services	No charge at UCSF; 5% coinsurance at Langley Porter Psychiatric Institute and all other UC Medical Centers	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: No charge at SHCS; \$5 copay/ visit Facility charges: 5% coinsurance	Office visit: \$15 copay/ visit Facility charges \$250 plus 10% coinsurance/visit	Office visit: 35% coinsurance Facility charges: \$250 plus 40% coinsurance/visit	Deductible waived for network and out-of-network provider physician outpatient visits.
	Substance use disorder inpatient services	No charge at UCSF; 5% coinsurance at Langley Porter Psychiatric Institute and all other UC Medical Centers	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	\$25 copayment/visit	\$25 copayment/visit	40% coinsurance	Copayment applies to initial visit only, thereafter no charge. Deductible waived for network providers .

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	Delivery and all inpatient services	No charge at UCSF; 5% coinsurance at other UC hospitals	\$250 plus 10% coinsurance/visit	\$500 plus 40% coinsurance/visit	Subject to utilization review for inpatient services beyond 48 hours for a 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	No charge	0% coinsurance	40% coinsurance	-----none-----
	Rehabilitation services	\$10 copay/visit	\$25% copay/visit	40% coinsurance	-----none-----
	Habilitation services	\$10 copay/visit	\$25% copay/visit	40% coinsurance	-----none-----
	Skilled nursing care	5% coinsurance	10% coinsurance	40% coinsurance	-----none-----
	Durable medical equipment	5% coinsurance	10% coinsurance	40% coinsurance	-----none-----
	Hospice service	5% coinsurance	10% coinsurance	40% coinsurance	-----none-----
If your child needs dental or eye care	Eye exam	Not covered	No charge	\$0 copay/visit	\$30 allowance/year for out-of-network <u>providers.</u>
	Glasses	Not covered	No charge	\$0 copay/glasses	\$45 frame allowance and \$25 lens allowance/year for out-of-network <u>providers.</u>
	Dental check-up	Not covered	No charge	No charge	<u>Deductible</u> 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 <u>excluded services.</u>)		
• Cosmetic surgery	• Long-term care	• Routine foot care (except when prescribed for diabetes)
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Infertility treatment	• Routine eye care (Adult)	

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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 (Coverage is 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, kwijigo holne' 866-940-8306.

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations when using an Anthem Network Provider. 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 \$6,540
- Patient pays \$1,000

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	\$300
Coinsurance	\$500
Limits or exclusions	\$0
Total	\$1,000

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	\$300
Coinsurance	\$100
Limits or exclusions	\$0
Total	\$600

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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 UC Family and 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.

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