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

**UC San Francisco Students and Covered Dependents**

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>There is no deductible for UC Family providers. For network providers: $200/person or $400/family; Out-of-network provider: $750/person or $1500/family.</td>
<td>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, network preventive services, emergency room, urgent care, acupuncture, chiropractic, physician office visits, family planning, medical evacuation, repatriation and prescription drugs.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. Pediatric dental: $60/person or $120/family. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For UC family providers: $2,000/person or $4,000/family. 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.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (866) 940-8306 for a list of network providers.</td>
<td>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</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage:

**What this Plan Covers & What You Pay For Covered Services**

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UC Family Provider (You will pay the least)</td>
<td>Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td>No charge at SHS; $25 copayment/visit (UC Family). No deductible.</td>
<td>$25 copayment /visit. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge at SHS; $10 copayment /visit (UC Family). No deductible.</td>
<td>$40 copayment /visit. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ Immunization</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge at SHCS for blood work; 5% coinsurance for UC Family x-ray and blood work</td>
<td>10% coinsurance</td>
</tr>
</tbody>
</table>

*All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.*

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.

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.

---

1. All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
2. 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.
3. 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.
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>UC Family Provider (You will pay the least)</th>
<th>Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
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<tbody>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>5% coinsurance</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>You should refer to your policy or plan document for details (*see page 30, 33, 38, 40, 69 &amp; 75).</td>
</tr>
</tbody>
</table>

### 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/](http://www.ucop.edu/ucship/plan-documents/).

- **Generic drugs**
  - $5 copayment /prescription at retail pharmacies/ Prescription. **Deductible** does not apply.
  - Retail: $25 copayment /prescription Mail Order $15 copayment/prescription. **Deductible** does not apply.
  - $5 plus any amount over the allowed amount/prescription. **Deductible** does not apply.

- **Preferred brand drugs**
  - $25 copayment /prescription at retail pharmacies/ Prescription. **Deductible** does not apply.
  - Retail: $25 copayment /prescription Mail Order $75 copayment/prescription. **Deductible** does not apply.
  - $25 plus any amount over the allowed amount/prescription. **Deductible** does not apply.

- **Non-preferred brand drugs**
  - $40 copayment /prescription at retail pharmacies/ Prescription. **Deductible** does not apply.
  - Retail: $40 copayment /prescription Mail Order $120 copayment/prescription. **Deductible** does not apply.
  - $40 plus any amount over the allowed amount/prescription. **Deductible** does not apply.

- **Specialty drugs**
  - $40 copayment /prescription at retail pharmacies/ Prescription. **Deductible** does not apply.
  - Retail: $40 copayment /prescription Mail Order $120 copayment/prescription. **Deductible** does not apply.
  - $40 plus any amount over the allowed amount/prescription. **Deductible** does not apply.

*For more information about limitations and exceptions, see plan or policy document at [www.ucop.edu/ucship](http://www.ucop.edu/ucship).*
### Summary of Benefits and Coverage

#### Pay For Covered Services

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<tr>
<td></td>
<td></td>
<td>UC Family Provider (You will pay the least)</td>
<td>Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>5% coinsurance</td>
<td>$250 plus 10% coinsurance /per admission</td>
<td>$250 plus 40% coinsurance /per admission</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>5% coinsurance, No deductible.</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$125 copayment /visit. Deductible does not apply.</td>
<td>$125 copayment /visit. Deductible does not apply.</td>
<td>$125 copayment /visit. Deductible does not apply.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>10% coinsurance, Deductible does not apply.</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copayment / visit. Deductible does not apply.</td>
<td>$25 copayment / visit. Deductible does not apply.</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>5% coinsurance, No deductible.</td>
<td>$250 plus 10% coinsurance /per admission</td>
<td>$500 plus 40% coinsurance /per admission</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>5% coinsurance, No deductible.</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>UC Family Provider (You will pay the least)</td>
<td>Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office visit: No charge at SHCS; $5 <strong>copayment</strong> /visit, no deductible. Facility charges: 5% <strong>coinsurance</strong>,</td>
<td>Office visit: $15 <strong>copayment</strong> /visit. <strong>Deductible</strong> does not apply. Facility charges $250 plus 10% <strong>coinsurance</strong> /per admission.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td></td>
<td>Office visit 35% <strong>coinsurance</strong> Facility charges: $250 plus 40% <strong>coinsurance</strong> /per admission.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge at UCSF; 5% coinsurance at Langley Porter Psychiatric Institute and all other UC Medical Centers. <strong>Deductible</strong> does not apply.</td>
<td>10% <strong>coinsurance</strong> + $250 <strong>copayment</strong>/per admission</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 <strong>copayment</strong>/initial visit only. <strong>Deductible</strong> does not apply.</td>
<td>$25 <strong>copayment</strong>/initial visit only. <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge at UCSF; 5% coinsurance at all other UC Medical Centers. <strong>Deductible</strong> does not apply.</td>
<td>10% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at [www.ucop.edu/ucship](http://www.ucop.edu/ucship).*
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<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>UC Family Provider (You will pay the least)</td>
<td>Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>No charge at UCSF; 5% coinsurance at all other UC Medical Centers</td>
<td>10% coinsurance /per admission + $250 copayment</td>
<td>40% coinsurance /per admission + $500 copayment</td>
<td>Subject to utilization review for inpatient services beyond 48 hours for vaginal birth and 96 hours for a cesarean birth; waived for emergency admissions. The maximum allowed amount is reduced by 25% for services and supplies provided by a non-contracting hospital.</td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge. No deductible.</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>Subject to utilization review.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$10 copayment /visit. No deductible.</td>
<td>$25 copayment /visit. No deductible.</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$10 copayment /visit. No deductible.</td>
<td>$25 copayment /visit. No deductible.</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>5% coinsurance. No deductible.</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Subject to utilization review.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>5% coinsurance. No deductible.</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>5% coinsurance. No deductible.</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge. No deductible.</td>
<td>No charge. No deductible.</td>
<td>$0 copayment/visit</td>
<td>$30 allowance/year for out-of-network providers.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>No charge. No deductible.</td>
<td>No charge. No deductible.</td>
<td>$0 copayment/glasses</td>
<td>$45 frame allowance and $25 lens allowance/year for out-of-network providers.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>Deductible waived for diagnostic and preventive services.</td>
</tr>
</tbody>
</table>
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Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery (For morbid obesity. Consult your policy or plan document)</td>
</tr>
<tr>
<td>• Hearing aids (limited to one hearing aid per ear every four years)</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside of the U.S.</td>
</tr>
<tr>
<td>• Routine foot care (if medically necessary)</td>
</tr>
<tr>
<td>• Weight loss programs (commercial weight loss programs are excluded)</td>
</tr>
</tbody>
</table>

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 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.
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.
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:
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijigo holne' 866-940-8306.

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...
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**different health plans. Please note these coverage examples are based on self-only coverage.**

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
<td>$200</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$1360</td>
<td>The total Joe would pay is</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$560</td>
<td></td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

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The plan would be responsible for the other costs of these EXAMPLE covered services.