Anthem Blue Cross Life and Health Insurance Company
University of California UC Care Plan

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

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual + 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.uc-care.org or by calling (844) 437-0486.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	UC Select Provider: **None** Anthem Preferred PPO Providers: **$250** Individual/ **$750** Family Does not apply to Preventive care, Emergency Room Services and Ambulance Services. Out-of-Network Providers: **$500** Individual/**$1,500** Family Does not apply to Emergency Room Services and Ambulance Services. Anthem Preferred PPO and Out-of-Network Providers deductibles are separate and do not count towards each other.	You must pay all 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 3 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 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$5,100** Individual / **$8,700** Family for UC Select Providers. **$6,600** Individual / **$13,200** Family for Anthem Preferred PPO Providers. **$8,600** Individual / **$19,200** Family for Out-of-Network Providers. UC Select and Anthem Preferred PPO Out of Pocket maximum amounts cross accumulate. UC Select/ Anthem Preferred PPO and Out-of-Network Providers Out of Pocket maximums do not cross accumulate.	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.

Questions: Call (844) 437-0486 or visit us at www.uc-care.org
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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (844) 437-0486 to request a copy.

Important Questions	Answers	Why this Matters:
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 3 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, Prudent Buyer PPO. For a list of Anthem Preferred PPO providers, see www.anthem.com/ca/uc or call **(844) 437-0486**.	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 3 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	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 In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.
- Certain services and prescription drugs require a prior-authorization, please refer to your plan booklet for more details.

Common Medical Event	Services You May Need	Your Cost if You Use a UC Select Provider	Your Cost if You Use an Anthem Preferred PPO 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	$20 copay per visit	20% coinsurance	50% coinsurance	--------none--------
	Specialist visit	$20 copay per visit	20% coinsurance	50% coinsurance	--------none--------
	Other practitioner office visit	Chiropractor N/A Acupuncture N/A	Chiropractor 20% coinsurance Acupuncture 20% coinsurance	Chiropractor 50% coinsurance Acupuncture 20% coinsurance	Chiropractor Coverage for Anthem Preferred Providers and Out-of-Network Providers combined is limited to 24 visits per benefit period. Combined with acupuncture. Acupuncture Coverage for Anthem Preferred Providers and Out-of-Network Providers combined is limited to 24 visits per benefit period. Combined with chiropractor services.
	Preventive care/ screening/ immunization	No cost share	No cost share	50% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office $20 copay per visit X-Ray – Office $20 copay per visit	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	$20 copay per visit	20% coinsurance	50% coinsurance	Coverage for Out-of-Network Providers is limited to $175 maximum per visit for outpatient hospital. Costs may vary by site of service.

Common Medical Event	Services You May Need	Your Cost if You Use a UC Select Provider	Your Cost if You Use an Anthem Preferred PPO Provider	Your Cost if You Use a Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available http://optumrx.com	Formulary Generic Drugs	**Retail Pharmacy** $5/30 day supply **UC & Specified Retail Pharmacies** $10/31-90 day supply		50%	Drug benefit and pharmacy network administrated by OptumRx. Retail covers up to a 30 day supply UC Pharmacies and Specific Retail Pharmacies up to a 31-90 day supply. OptumRx Home Delivery Program only up to a 90 day supply.
	Formulary Brand Name Drugs	**Retail Pharmacy** $25/30 day supply **UC & Specified Retail Pharmacies** $50/31-90 day supply		50%	
	Non-Formulary Brand Name Drugs	**Retail Pharmacy** $40/30 day supply **UC & Specified Retail Pharmacies** $80/31-90 day supply		50%	
	Specialty Drugs	**BriovaRx and Select UC Pharmacies** 30% coinsurance up to $150 copay maximum		Out of Network Not Covered	Specialty Drug benefit administrated by BriovaRx/OptumRx.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per surgery	20% coinsurance	Out of Network Not Covered	Coverage for Out-of-Network Providers is limited to $175 maximum per visit.
	Physician/surgeon fees	No cost share	20% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	$200 copay per visit	$200 copay per visit	Covered as In-Network	If directly admitted to a hospital, ER copay is waived.
	Emergency medical transportation	N/A	$200 copay per trip	Covered as In-Network	--------none--------
	Urgent care	$20 copay per visit	20% coinsurance	50% coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use a UC Select Provider	Your Cost if You Use an Anthem Preferred PPO Provider	Your Cost if You Use a Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per admit	20% coinsurance	50% coinsurance	Coverage for Out-of-Network Providers is limited to $300 maximum per day.
	Physician/surgeon fee	No cost share	20% coinsurance	50% coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit 1- 3 No cost share Visit 4+ $20 copay per visit Facility Charges $20 copay per visit		Office Visit 50% coinsurance Facility Charges 50% coinsurance	--------none--------
	Mental/Behavioral health inpatient services	$250 copay per admit		50% coinsurance	This is for Inpatient facility fees
	Substance use disorder outpatient services	Office Visit 1- 3 No cost share Visit 4+ $20 copay per visit Facility Charges $20 copay per visit		Office Visit 50% coinsurance Facility Charges 50% coinsurance	--------none--------
	Substance use disorder inpatient services	$250 copay per admit		50% coinsurance	This is for Inpatient facility fees
If you are pregnant	Prenatal and postnatal care	$20 copay per visit	20% coinsurance	50% coinsurance	Copay applies for initial visit only. There may be other levels of cost share that are contingent on how services are provided
	Delivery and all inpatient services	$250 copay per admit	20% coinsurance	50% coinsurance	Coverage for Out-of-Network Providers is limited to $300 maximum per day.
If you need help recovering or have other special health needs	Home health care	N/A	20% coinsurance	50% coinsurance	Coverage for Anthem Preferred Providers and Out-of-Network Providers combined is limited to 100 visits per benefit period.
	Rehabilitation services	$20 copay per visit	20% coinsurance	50% coinsurance	Coverage for Out-of-Network Providers is limited to $175 maximum per visit for physical, occupational and speech therapy combined.

Common Medical Event	Services You May Need	Your Cost if You Use a UC Select Provider	Your Cost if You Use an Anthem Preferred PPO Provider	Your Cost if You Use a Out-of-Network Provider	Limitations & Exceptions
	Habilitation services	$20 copay per visit	20% coinsurance	50% coinsurance	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	N/A	20% coinsurance	50% coinsurance	Coverage for Anthem Preferred Providers and Out-of-Network Providers combined is limited to 100 days limit per benefit period.
	Durable medical equipment	N/A	20% coinsurance	50% coinsurance	--------none--------
	Hospice service	N/A	20% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	Not covered	--------none--------

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)
- 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 (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 only.
- Chiropractic care
- Hearing Aids- Covered at 50%/ limited to $2,000 every 36 mos.
- Infertility limited to medical diagnosis of cause.

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.)
• Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 333-5730. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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:

ATTN: Grievances and 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.**

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:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm.Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

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** $6,780
- **Patient pays** $760

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	$0
Copays	$590
Coinsurance	$0
Limits or exclusions	$170
Total	$760

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

- **Amount owed to providers:** $5,400
- **Plan pays** $860
- **Patient pays** $4,540

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	$0
Copays	$340
Coinsurance	$0
Limits or exclusions	$4,200
Total	$4,540

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 in-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**, **co payments**, 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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