The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.UChealthplans.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (866) 406-1182 to request a copy.

<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>$0/individual or $0/family for UC Select Providers. $500/individual or $1,000/family for Anthem Preferred Providers. $750/individual or $1,750/family for Out-of-Network Providers.</td>
<td>Generally, you must pay all of 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. Preventive care for UC Select and Anthem Preferred Providers, Emergency, and Ambulance services.</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>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$6,100/individual or $9,700/family for UC Select Providers. $7,600/individual or $14,200/family for Anthem Preferred Providers. $9,600/individual or $20,200/family for Out-of-Network Providers.</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-billing charges, expenses paid for infertility services, 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, UC Select and Anthem Preferred. See <a href="http://www.UChealthplans.com">www.UChealthplans.com</a> or call (866) 406-1182 for a list</td>
<td>You pay the least if you use a provider in UC Select. You pay more if you use a provider in Anthem 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 provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-</td>
</tr>
</tbody>
</table>

CA/L/A/UniversityofCaliforniaUCarePlan-PPO-NA/NA-NA/NA/01-21
Do you need a referral to see a specialist?  
No. You can see the specialist you choose without a referral.

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UC Select Provider (You will pay the least)</td>
<td>Anthem Preferred Provider (You will pay more)</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$20/visit</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$5/prescription (preferred retail, participating retail, and mail order – 30 days); $10/prescription (preferred retail and mail order – 90 days); $15/prescription (participating retail – 90 days)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred / Brand</td>
<td>$25/prescription (preferred retail, participating retail, and mail order – 30 days); $50/prescription (preferred retail, participating retail, and mail order – 90 days); $75/prescription (participating retail – 90 days)</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred / Brand</td>
<td>$40/prescription (preferred retail, participating retail, and mail order – 30 days); $80/prescription (preferred retail, participating retail, and mail order – 90 days)</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.UHealthplans.com.
<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 Select Provider (You will pay the least)</td>
<td>Anthem Preferred Provider (You will pay more)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>participating retail, and mail order – 90 days; $120/prescription (participating retail – 90 days)</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>30% coinsurance; $150 maximum per prescription (select specialty pharmacies)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100/surgery 30% coinsurance 50% coinsurance</td>
<td>Coverage for Out-of-Network Provider is limited to $175 maximum/visit.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge 30% coinsurance 50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$300/visit $300/visit deductible does not apply</td>
<td>Covered as In-Network If directly admitted to a hospital, ER copay is waived. No charge for Emergency Room Physician Fee.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not Applicable $200/trip deductible does not apply</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20/visit $20/visit deductible does not apply</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250/admission 30% coinsurance 50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge 30% coinsurance 50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit: No charge for first 3 visit then $20/visit deductible does not apply Other Outpatient: $20/visit deductible does not apply</td>
<td>Office Visit: 50% coinsurance Other Outpatient: 50% coinsurance</td>
</tr>
</tbody>
</table>

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<td></td>
<td>UC Select Provider (You will pay the least)</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>$250/admission deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Office visits</td>
<td>$20/visit for initial visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$250/admission</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Home health care</td>
<td>Not Applicable</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$20/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$20/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Not Applicable</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Not Applicable</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>Not Applicable</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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<table>
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<tr>
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<th>Services You May Need</th>
<th>UC Select Provider (You will pay the least)</th>
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<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>*See Vision Services section</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>*See Dental Services section</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Eye exams for a child
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental care (adult)
- Glasses for a child
- Private-duty nursing
- Weight loss programs
- Dental Check-up
- Routine eye care (adult)

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture 24 visits/benefit period combined with chiropractor for Anthem Preferred Providers and Out-of-Network Providers.
- Hearing aids $2,000 maximum/every 36 months.
- Bariatric surgery
- Infertility Treatment - 2 cycles per lifetime combined for GIFT, ZIFT and IVF (all infertility services are excluded from OOPM)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care 24 visits/benefit period combined with acupuncture for Anthem Preferred Providers and Out-of-Network Providers.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

* For more information about limitations and exceptions, see plan or policy document at www.UHealthplans.com.
Does this plan provide Minimum Essential Coverage?  Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards?  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.

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

* For more information about limitations and exceptions, see plan or policy document at www.UChealthplans.com.
## About these Coverage Examples:

**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 your 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 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 in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td><strong>Other copayment</strong></td>
<td>$20</td>
<td>$20</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)

**Total Example Cost** $12,700

In this example, Peg would pay:

- **Cost Sharing**
  - **Deductibles** $0
  - **Copayments** $650
  - **Coinsurance** $0

**What isn’t covered**
- Limits or exclusions $60

**The total Peg would pay is** $710

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)

**Total Example Cost** $5,600

In this example, Joe would pay:

- **Cost Sharing**
  - **Deductibles** $0
  - **Copayments** $520
  - **Coinsurance** $0

**What isn’t covered**
- Limits or exclusions $55

**The total Joe would pay is** $575

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

**Total Example Cost** $2,800

In this example, Mia would pay:

- **Cost Sharing**
  - **Deductibles** $0
  - **Copayments** $1,360
  - **Coinsurance** $15

**What isn’t covered**
- Limits or exclusions $0

**The total Mia would pay is** $1,375

---

**NOTE:** This Summary of Benefit and Coverage attempts to show you how you and the plan share the cost for covered health care services. Any summary of benefits or cost sharing principals represents only a brief description of your benefits. Please read the booklet carefully to learn about provisions, benefits and exclusions. If any perceived conflict exists between this summary and the Plan terms, the Plan terms govern.

The plan would be responsible for the other costs of these EXAMPLE covered services.
The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (866) 406-1182


Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով։ Թարգմանչի հետ խոսելու համար զանգահարեք (866) 406-1182:

Basa (Bàsì Wùdù): M dyi dyi-die-dè bë bécé bá céè-dè nià ke dyi ni, c mòn dyi-bëdéèin-dè bë m ké gbo-krá-krá ké bò kró dé m bídí-wùdùùn bò pídyi. Bë m ké wùdù-zììn-nyò qò gbo wùdù ke, dà (866) 406-1182.

Bengali (বাংলা): যদি এই দফায়ের বিষয়ে আপনার কোন প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিস্তারিত সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন তুলনামূলক সাথে কথা বলার জন্য (866) 406-1182 -ভে কল করুন।

Burmese (မြန်မာ): မြန်မာလိုင်းနှင့် အတူ အကြောင်းပြောပြပါတယ်။ အမိန့်နှင့် အရောင်းဆိုင်ရာ အကြောင်းပြောပြပါတဲ့ ပျမ်းမျှ ကြည့်နှုန်းရန် (866) 406-1182 ဆရာကလေး။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (866) 406-1182。

Dinka (Dinka): Na nog thièèe nè ke de yà thorè, ke yìn nòg loŋ bë yi kuony ku wer akè bë geër yìñ ne thòŋ du ke cìm wëu täaŋë ke pìny. Te kòr yìn ba jam wènè ran ye thòk getìyìc, ke yìn col (866) 406-1182.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (866) 406-1182.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند داردید، این حق را دارید که اطلاعات و کمک را بدون هیچ 

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (866) 406-1182.
Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (866) 406-1182.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (866) 406-1182.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્ન પ્રશ્ન કરો હોય તો, કોઈપણ અબ્યાર વગર અપની ભાષામાં મદદ અને માહહતી મેળવવાની તમને અધિકાર છે. દુભાષયાથી સાથે વાત કરવા માટે, કોલ કરો (866) 406-1182.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entéprèt, rele (866) 406-1182.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिया से बात करने के लिए, कॉल करें (866) 406-1182.

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thibab lus qhia hais ua koj hom lus yam tsim xam tus ngu. Tshawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (866) 406-1182.

**Igbo (Igbo):** O bùrụ na i nwere ajụjụ ọ bula gbasara akwụkwọ a, i nwere ikike ịnweka enyemaka na ozi n'asụsụ ị na akwụghị ịgwo ọ bula. Ka ị na ọkọwa okwu kwuo okwu, kpọọg (866) 406-1182.

**Ilokano (Ilokano):** Nu addaan ka iti aniamaan a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulon ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (866) 406-1182.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (866) 406-1182.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (866) 406-1182.

**Japanese (日本語):** この文書についてなにか不明な点があれば、あなたにはあなたの言語で無料で支授を受け情報を得る権利があります。通訳と話すには、(866) 406-1182 にお電話ください。
Language Access Services:

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