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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$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.	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.
Are there services covered before you meet your deductible?	Yes. Preventive care for UC Select and Anthem Preferred Providers, Emergency, and Ambulance services.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$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.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, expenses paid for infertility services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, UC Select and Anthem Preferred. See www.UChealthplans.com or call (866) 406-1182 for a list	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-

	of network providers.	network provider for some services (such as lab work). Check with your provider before you get services.
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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Select Provider (You will pay the least)	Anthem Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	30% coinsurance	50% coinsurance	--------none--------
	Specialist visit	$20/visit	30% coinsurance	50% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20/visit	30% coinsurance	50% coinsurance	Cost may vary by site of service.
	Imaging (CT/PET scans, MRIs)	$20/visit	30% coinsurance	50% coinsurance	Coverage for Out-of-Network Provider is limited to $175 maximum/visit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Tier 1 - Typically Generic	$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)		50% coinsurance	Preferred retail, participating retail, and mail order cover up to a 90-day supply. Select specialty pharmacies cover up to a 30-day supply. Certain limitations may apply, including, for example: prior authorization and quantity limits. *See prescription drug section of the plan or policy.
	Tier 2 - Typically Preferred / Brand	$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)		50% coinsurance	
	Tier 3 - Typically Non-Preferred / Brand	$40/prescription (preferred retail, participating retail, and mail order – 30 days); $80/prescription (preferred retail,		50% coinsurance	

* For more information about limitations and exceptions, see **plan** or policy document at www.UChealthplans.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Select Provider (You will pay the least)	Anthem Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		participating retail, and mail order – 90 days); $120/prescription (participating retail – 90 days)			
	Tier 4 - Typically Specialty (brand and generic)	30% coinsurance; $150 maximum per prescription (select specialty pharmacies)		N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/surgery	30% coinsurance	50% coinsurance	Coverage for Out-of-Network Provider is limited to $175 maximum/visit.
	Physician/surgeon fees	No charge	30% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$300/visit	$300/visit deductible does not apply	Covered as In-Network	If directly admitted to a hospital, ER copay is waived. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	Not Applicable	$200/trip deductible does not apply	Covered as In-Network	--------none--------
	Urgent care	$20/visit	$20/visit deductible does not apply	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission	30% coinsurance	50% coinsurance	Coverage for Out-of-Network Provider is limited to $300 maximum/day. If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay.
	Physician/surgeon fees	No charge	30% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No charge for first 3 visit then $20/visit deductible does not apply Other Outpatient: $20/visit deductible does not apply		Office Visit: 50% coinsurance Other Outpatient: 50% coinsurance	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at www.UChealthplans.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Select Provider (You will pay the least)	Anthem Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	$250/admission deductible does not apply		50% coinsurance	If no pre-authorization is obtained for out of network providers, there will be an additional $250 copay. No charge for Inpatient Physician Fee UC Select Providers or Anthem Preferred Providers. 50% coinsurance for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	$20/visit for initial visit	30% coinsurance	50% coinsurance	Coverage for Out-of-Network Provider is limited to $300 maximum/day. If no pre-authorization is obtained for Inpatient out of network providers, there will be an additional $250 copay. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250/admission	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not Applicable	30% coinsurance	50% coinsurance	100 visits/benefit period for Anthem Preferred Providers and Out-of-Network Providers combined.
	Rehabilitation services	$20/visit	30% coinsurance	50% coinsurance	*See Therapy Services section
	Habilitation services	$20/visit	30% coinsurance	50% coinsurance	
	Skilled nursing care	Not Applicable	30% coinsurance	50% coinsurance	100 days limit/benefit period for Anthem Preferred Providers and Out-of-Network Providers combined. $300 maximum/day for Out-of-Network Providers.
	Durable medical equipment	Not Applicable	30% coinsurance	50% coinsurance	--------none--------
	Hospice services	Not Applicable	30% coinsurance	50% coinsurance	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at www.UChealthplans.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UC Select Provider (You will pay the least)	Anthem Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

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:

* For more information about limitations and exceptions, see **plan** or policy document at www.UChealthplans.com.

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

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *copayment*	$20
Hospital (facility) *copayment*	$250
Other *copayment*	$20

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**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *copayment*	$20
Hospital (facility) *copayment*	$250
Other *copayment*	$20

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**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copayment*	$20
Hospital (facility) *copayment*	$250
Other *copayment*	$20

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.

By authority of the Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations for Faculty and Staff, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits–particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their Human Resources Office and retirees should call the UC Retirement Administration Service Center (800-888-8267).

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, CA 94607, and for faculty to the Office of Academic Personnel and Programs, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (866) 406-1182 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (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 հետևյալ հեռախոսահամարով՝ (866) 406-1182:

Bassa (Bàsɔ̀ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (866) 406-1182.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (866) 406-1182 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (866) 406-1182 သို့ ခေါ်ဆိုပါ။

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 nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (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 (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (866) 406-1182 تماس بگیرید.

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 પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા 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 entèprèt, rele (866) 406-1182.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये 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 thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (866) 406-1182.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (866) 406-1182.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong 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ご不明な点があれば、あなたにはあなたの言語で無料で支援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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