The summary of Benefits 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.ucop.edu/ucship/plan-documents/](http://www.ucop.edu/ucship/plan-documents/) or by calling 1-866-940-8306. 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](http://www.healthcare.gov/sbc-glossary).

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>There is no deductible for UC Family providers. For network providers: $500/person or $1000/family; Out-of-network provider: $1000/person or $2000/family. The <strong>deductible</strong> will not apply to network preventive services, physician office visits, rehabilitation or habilitation; network and out-of-network emergency or urgent care, medical evacuation, repatriation or prescription drugs.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes, in-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 services even if you haven’t yet met the deductible amount. A copayment or coinsurance may apply.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. Pediatric dental: $60/person or $120/family</td>
<td>You must pay all the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit of this plan?</strong></td>
<td>Yes. For UC family providers: $2500/person or $5000/family. network providers: $3350/person or $6700/family. For out-of-network providers: $7000/person or $14000/family. For prescriptions $1000/person or $2000 family. For pediatric dental: $1000/person or $2000/family.</td>
<td>The <strong>out-of-pocket limit</strong> 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.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*
Anthem Blue Cross: University of California Student Health Insurance Plan (UC SHIP)
UC San Diego Students and Covered Dependents Coverage Period begins on or after 08/01/2017
Coverage for: Student/Family | Plan Type: PPO

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

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<tr>
<th>Common Medical Event</th>
<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>
</thead>
<tbody>
<tr>
<td></td>
<td></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>
<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 provider’s charge and what your plan pays (balance billing).</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Yes, Students contact the Student Health Services (SHS). Dependents call 866-940-8306 for a list of network providers.</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<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>No charge (SHS); $5 copayment/visit (UC Family)</td>
<td>$20 copayment/visit</td>
<td>40% coinsurance</td>
<td>Deductible waived for UC Family and network providers. 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.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge (SHS); $10 copayment/visit (UC Family)</td>
<td>$30 copayment/visit</td>
<td>40% coinsurance</td>
<td>Deductible waived for UC Family and network providers.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/Immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>Deductible waived for UC Family and network providers.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Deductible waived for UC Family providers.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period begins on or after 08/01/2017**

**Coverage for:** Student/Family | **Plan Type:** PPO

### Common Medical Event

<table>
<thead>
<tr>
<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><strong>If you need drugs to treat your illness or condition</strong>&lt;br&gt;More information about prescription drug coverage is available at <a href="http://www.ucop.edu/UCSHIP/plandocuments/">www.ucop.edu/UCSHIP/plandocuments/</a>.&lt;br&gt;More information about prescription drug coverage is available at <a href="http://www.ucop.edu/UCSHIP/plandocuments/">www.ucop.edu/UCSHIP/plandocuments/</a>.</td>
<td><strong>UC Family Provider (You will pay the least)</strong>&lt;br&gt;<strong>Network Provider</strong>&lt;br&gt;<strong>Out-of-Network Provider (you will pay the most)</strong></td>
<td><strong>Deductible</strong> waived for UC Family providers. Costs may vary by site of service. You should refer to your policy or plan document for details.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance&lt;br&gt;$5 copay at SHS, $10 copay UC Family pharmacies/prescription</td>
<td>20% coinsurance&lt;br&gt;$10 copay/ prescription at retail pharmacies</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$25 copay at SHS, $40 copay UC Family pharmacies/prescription</td>
<td>$40 copay/ prescription at retail pharmacies</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$40 copay at SHS, $100 copay UC Family pharmacies/prescription</td>
<td>$100 copay/ prescription at retail pharmacies</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>10% up to a maximum of $100 copay/prescription</td>
<td>10% up to a maximum of $100 copay/prescription</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*

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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>If you need immediate medical attention</td>
<td>Emergency room services</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>$125 copayment/visit</td>
<td>$125 copayment/visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$125 copayment/visit</td>
<td>$125 copayment/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copayment/visit</td>
<td>$50 copayment/visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 copayment/visit</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No charge for air ambulance.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>$500 copayment + 20% coinsurance/visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 copayment + 20% coinsurance/visit</td>
<td>$500 copayment + 40% coinsurance/visit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period begins on or after 08/01/2017**  
**Coverage for:** Student/Family | **Plan Type:** PPO

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<tr>
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</tr>
</thead>
</table>
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | UC Family Provider (You will pay the least)  
Office visit: No charge (SHS)/$10 copay (UC Family)/visit; Facility charges; 5% coinsurance  
Network Provider  
Office visit: $25 copay/visit  
Facility charges: 10% coinsurance + $250 Copayment  
Out-of-Network Provider (you will pay the most)  
Office visit: 40% coinsurance  
Facility charges: 40% coinsurance | Deductible, waived for UC Family providers. |
| | Inpatient services | 5% coinsurance  
Network Provider  
10% coinsurance + $500 copayment  
Out-of-Network Provider (you will pay the most)  
40% coinsurance + $500 copayment | Deductible, waived for UC Family providers. This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| **If you are pregnant** | Office visit | $5 copay/visit; initial visit only  
Network Provider  
$20 copay/visit; initial visit only  
Out-of-Network Provider (you will pay the most)  
40% coinsurance | Copayment applies to initial visit only, thereafter no charge. Deductible, waived for UC Family and network providers. |
| | Childbirth/delivery professional services | 10% coinsurance  
Network Provider  
20% coinsurance  
Out-of-Network Provider (you will pay the most)  
40% coinsurance | Deductible, waived for UC Family providers. |
| | Childbirth/delivery facility services | 10% coinsurance  
Network Provider  
20% coinsurance + $500 copayment  
Out-of-Network Provider (you will pay the most)  
40% coinsurance/visit + $500 copayment | Deductible, waived for UC Family providers. Subject to utilization review for inpatient services beyond 48 hours for vaginal birth and 96 hours for a cesarean birth; waived for emergency admissions. Services not covered if not medically necessary. |

*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*

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

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

**UC San Diego Students and Covered Dependents**

**Coverage Period begins on or after 08/01/2017**

**Coverage for:** Student/Family | **Plan Type:** PPO

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UC Family Provider (You will pay the least)</td>
<td>Network Provider</td>
<td>Out-of-Network Provider (you will pay the most)</td>
</tr>
<tr>
<td></td>
<td><strong>What You Will Pay</strong></td>
<td>No charge</td>
<td>Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

### If you need help recovering or have other special health needs

- **Home health care**: No charge
- **Rehabilitation services**: $15 copayment/visit, $30 copayment/visit, 40% coinsurance
- **Habilitation services**: $15 copayment/visit, $30 copayment/visit, 40% coinsurance
- **Skilled nursing care**: 10% coinsurance, 20% coinsurance, 40% coinsurance
- **Durable medical equipment**: 10% coinsurance, 20% coinsurance, 40% coinsurance
- **Hospice service**: 10% coinsurance, 20% coinsurance, 40% coinsurance

### If your child needs dental or eye care

- **Children’s eye exam**: No charge
- **Children’s glasses**: No charge
- **Children’s dental check-up**: No charge

*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
<th>Services Your Plan Generally Covers (Please see your policy or plan document for limitations.)</th>
</tr>
</thead>
</table>
| • Cosmetic surgery  
• Dental care (Adult)  
• Infertility treatment  
• Routine foot care (unless you have been diagnosed with diabetes)  
• Weight loss programs (commercial) | • Long-term care  
• Private-duty nursing  
• Routine eye care (Adult)  
• Routine foot care (if you have been diagnosed with diabetes)  
• Weight loss programs (commercial) |
| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document..) | |
| • Acupuncture  
• Bariatric surgery (For morbid obesity. Consult your policy or plan document)  
• Hearing aids (limited to one hearing aid per ear every four years)  
• Non-emergency care when traveling outside of the U.S.) | • Chiropractic care  
• Hearing aids (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: 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 claims, 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

Language Access Services:  
Navajo (Dine): Dinek'ehgo shika at'o'hwol ninisingo, kwijjigo holne' 866-940-8306.

*For more information about limitations and exceptions, see the plan or policy document at www.ucop.edu/UCSHIP
Anthem Blue Cross: University of California Student Health Insurance Plan (UC SHIP)  
UC San Diego Students and Covered Dependents

Coverage Period begins on or after 08/01/2017

Coverage for: Student/Family | Plan Type: PPO

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

- **What this Plan Covers & What it Costs**
- **Coverage for:** Student/Family | Plan Type: PPO

---

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

---

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

- The plan’s overall deductible: $500
- Specialist (cost sharing): $20
- Hospital (facility) [cost sharing]: $500+10%
- Other [cost sharing]: 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**: $12,731

In this example, Peg would pay:

- Deductibles: $500
- Copayments: $600
- Coinsurance: $1,000

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: $2,000

---

### Managing Joe’s Type 2 Diabetes
(a year of routine network care of a well-controlled condition)

- The plan’s overall deductible: $500
- Specialist (cost sharing): $30
- Hospital (facility) [cost sharing]: $500+20%
- Other [cost sharing]: 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**: $7,389

In this example, Joe would pay:

- Deductibles: $300
- Copayments: $800
- Coinsurance: $300

**What isn’t covered**

- Limits or exclusions: $60
- The total Joe would pay is: $1,460

---

### Mia’s Simple Fracture
(network emergency room visit and follow up care)

- The plan’s overall deductible: $500
- Specialist (cost sharing): $30
- Hospital (facility) [cost sharing]: $500+20%
- Other [cost sharing]: 30%

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**: $1,925

In this example, Mia would pay:

- Deductibles: $300
- Copayments: $300
- Coinsurance: $100

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: $700

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*For more information about limitations and exceptions, see the plan or policy document at [www.ucop.edu/UCSHIP](http://www.ucop.edu/UCSHIP)*