## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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

**Hastings College of the Law Students & Dependents**

**Coverage Period begins on or after 08/01/2020**

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

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### Important Questions

<table>
<thead>
<tr>
<th><strong>Important Questions</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>There is no deductible for UC Family providers. For network providers: $50/person or $400/family; Out-of-network provider: $500/person or $1000/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. For network providers: $2,000/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>
</tbody>
</table>

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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). 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.

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>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</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>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 at Carbon Health; $5 copayment/visit (UC Family). <strong>Deductible</strong> does not apply.</td>
<td>$20 <strong>copayment</strong>/visit. <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge at Carbon Health; $10 copayment/visit (UC Family). <strong>Deductible</strong> does not apply.</td>
<td>$10 <strong>copayment</strong>/Visit. <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge. <strong>Deductible</strong> does not apply.</td>
<td>No charge. <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% <strong>coinsurance</strong></td>
<td>10% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

Yes. See [www.anthem.com/ca](http://www.anthem.com/ca) or call (866) 940-8306 for a list of **network providers**.

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**.

Yes for students and no for dependents.

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). 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.

**copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UC Family Provider (You will pay the least)</td>
<td>Network Provider</td>
</tr>
<tr>
<td>Imaging</td>
<td>(CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$5 copayment /prescription at retail pharmacies/Prescription. <strong>Deductible does not apply.</strong></td>
<td>$5 copayment at retail pharmacies/prescription. <strong>Deductible does not apply.</strong></td>
<td>$5 plus any amount over the allowed amount/prescription. <strong>Deductible does not apply.</strong></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$25 copayment/prescription at retail pharmacies/Prescription. <strong>Deductible does not apply.</strong></td>
<td>Retail: $25 copayment/prescription. <strong>Deductible does not apply.</strong></td>
<td>$25 plus any amount over the allowed amount/prescription. <strong>Deductible does not apply.</strong></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$40 copayment /prescription at retail pharmacies/Prescription. <strong>Deductible does not apply.</strong></td>
<td>Retail: $40 copayment/prescription. <strong>Deductible does not apply.</strong></td>
<td>$40 plus any amount over the allowed amount/prescription. <strong>Deductible does not apply.</strong></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$40 copayment /prescription at retail pharmacies/Prescription. <strong>Deductible does not apply.</strong></td>
<td>Retail: $40 copayment/prescription. <strong>Deductible does not apply.</strong></td>
<td>$40 plus any amount over the allowed amount/prescription. <strong>Deductible does not apply.</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).*

You should refer to your policy or plan document for details (*see pages 29, 32, 37, 38, 68 & 77).*

*Covers up to a 30-day supply of medications and 180-days for oral contraceptives at retail pharmacies. Covers up to 90 days of medication and up to 180 days of oral contraceptives through Mail Order. **Network** pharmacies are contracted with OptumRx.*
<table>
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</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance, Deductible does not apply.</td>
<td>An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or plan documents for details (*see pages 26, 35, 37, 43 &amp; 82).</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance, Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$125 copayment/visit. Deductible does not apply.</td>
<td>Copayment waived if admitted. Member may be responsible for any costs above the allowed amount for an out-of-network provider.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copayment/visit. No deductible.</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance, Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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<th>Limitations, Exceptions, &amp; Other Important Information</th>
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</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td><strong>UC Family Provider (You will pay the least)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office visit: $15 copayment/visit. Facility charges: 10% coinsurance. Provider Services: 10% coinsurance</td>
<td>An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or plan documents for details (*see pages 34, 79, 80 &amp; 82).</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office visit: 40% coinsurance. Facility charges: 40% coinsurance + $250 copayment/per admission. Provider Services: 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Office visits</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Copayment</strong>                      Copayment applies to initial visit only, thereafter no charge. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5 copayment/initial visit only. Facility charges: 10% coinsurance. Provider Services: 10% coinsurance</td>
<td>An additional 25% penalty is assessed for services and supplies provided by a Non-Contracting Hospital. You should refer to your policy or plan documents for details (*see pages 34, 35, 79 &amp; 80).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$20 copayment/initial visit only. Facility charges: 10% coinsurance. Provider Services: 10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance. Facility charges: 40% coinsurance + $250 copayment/per admission. Provider Services: 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>40% coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>40% coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>40% coinsurance</strong></td>
<td></td>
</tr>
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<td></td>
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<td><strong>Copayment</strong>                      Copayment applies to initial visit only, thereafter no charge. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>40% coinsurance</strong></td>
<td></td>
</tr>
</tbody>
</table>

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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>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance. Deductible does not apply.</td>
<td>10% coinsurance/visit + $250 copayment/per admission.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery facility services</td>
<td>No charge.</td>
<td>No charge.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>$10 copayment/visit. No deductible.</td>
<td>$10 copayment/visit. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$10 copayment/visit. No deductible.</td>
<td>$10 copayment/visit. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$10 copayment/visit. No deductible.</td>
<td>$10 copayment/visit. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge. No deductible.</td>
<td>No charge. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge. No deductible.</td>
<td>No charge. No deductible.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>
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>• Chiropractic care</td>
</tr>
<tr>
<td>• Hearing aids (limited to one hearing aid per ear every four years)</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 at'ohwol ninisingo, kwiijigo holne' 866-940-8306.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
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</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of network pre-natal care and a hospital delivery)</td>
<td>(a year of routine network care of a well-controlled condition)</td>
<td>(network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>▪ The plan’s overall deductible</td>
<td>▪ The plan’s overall deductible</td>
<td>▪ The plan’s overall deductible</td>
</tr>
<tr>
<td>$50</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>▪ Specialist copayment</td>
<td>▪ Specialist copayment</td>
<td>▪ Specialist copayment</td>
</tr>
<tr>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>▪ Hospital (facility) coinsurance</td>
<td>▪ Hospital (facility) coinsurance</td>
<td>▪ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>$250+10%</td>
<td>$250+10%</td>
<td>$250+10%</td>
</tr>
<tr>
<td>▪ Other coinsurance</td>
<td>▪ Other coinsurance</td>
<td>▪ Other coinsurance</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
<th>$7,400</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$100</td>
<td>$1,800</td>
<td></td>
</tr>
</tbody>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$600</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$300</td>
<td>$60</td>
<td></td>
</tr>
</tbody>
</table>

- **What isn’t covered**
  - Limits or exclusions: $60
  - The total Peg would pay is: $2,010
  - The total Joe would pay is: $910
  - The total Mia would pay is: $410

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