Anthem Blue Cross Life and Health Insurance Company
University of California at Berkeley Custom PPO Student Health Plan With Student Health Center (& Rx)

Coverage Period: 08/15/2016 - 07/31/2017

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

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 https://eoc.anthem.com/eocdps/ca/fi or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** Student/**$900** Family for PPO and Non-PPO Providers. Does not apply to PPO Preventive Care, Primary Care and Specialist Visit, Transgender and Bariatric surgery travel, Urgent Care and Emergency Room Service.	You must pay all the 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 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$60** Student/**$180** Family for Pediatric Dental. There are no other specific **deductibles**.	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.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,200** Student/**$6,400** Family for PPO Providers. **$6,500** Student/**$13,000** Family for Non-PPO Providers. PPO Provider and Non-PPO Provider out-of-pocket are separate and do not count towards each other. This plan has a separate Pediatric Dental Out-of-Pocket Maximum of **$1,000** Student/**$2,000** Family for PPO Providers.	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.
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 2 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. See www.anthem.com/ca or call 1-855-333-5730 for a list of PPO Providers.	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 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-855-333-5730 or visit us at www.anthem.com/ca. 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 1-855-333-5730 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes. Please contact the UC Berkeley SHIP Office for a referral.	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**.
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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** Copay/Visit	**40%** Coinsurance	**Deductible** waived for PPO Provider.
	Specialist visit	**$15** Copay/Visit	**40%** Coinsurance	**Deductible** waived for PPO Provider.
	Other practitioner office visit	Chiropractor **$15** Copay/Visit Acupuncturist **$15** Copay/Visit	Chiropractor **40%** Coinsurance Acupuncturist **40%** Coinsurance	**Deductible** waived for PPO Provider.
	Preventive care/screening/immunization	No Cost Share	**40%** Coinsurance	**Deductible** waived for PPO Provider
If you have a test	Diagnostic test (x-ray, blood work)	**10%** Coinsurance	**40%** Coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	**10%** Coinsurance	**40%** Coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&provtype=Rx	Tier 1 - Typically Generic *(includes diabetic supplies)*	**$5** Copay/Prescription for Retail Pharmacy **$5** Copay/Prescription for Mail Order	**$5** Copay/Prescription plus **40%** Coinsurance for Retail Pharmacy **$5** Copay/Prescription plus **40%** Coinsurance for Mail Order	Covers up to a 30 day supply for retail pharmacies and a 90 day supply for mail order. Not subject to the **deductible**.
	Tier 2 - Typically Preferred / Brand	**$25** Copay/Prescription for Retail Pharmacy **$50** Copay/Prescription for Mail Order	**$25** Copay/Prescription plus **40%** Coinsurance for Retail Pharmacy **$50** Copay/Prescription plus **40%** Coinsurance for Mail Order	Covers up to a 30 day supply for retail pharmacies and a 90 day supply for mail order. Not subject to the **deductible**.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	**$40** Copay/Prescription for Retail Pharmacy **$80** Copay/Prescription for Mail Order	**$40** Copay/Prescription plus **40%** Coinsurance for Retail Pharmacy **$80** Copay/Prescription plus **40%** Coinsurance for Mail Order	Covers up to a 30 day supply for retail pharmacies and a 90 day supply for mail order. Not subject to the **deductible**.
	Tier 4 - Typically Specialty Drugs	Not Applicable	Not Applicable	--------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	**40%** Coinsurance	Certain surgeries are subject to utilization review for PPO and Non-PPO facilities.
	Physician/surgeon fees	**10%** Coinsurance	**40%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	**$100** Copay/Visit	**$100** Copay/Visit	Copayment waived if admitted; **deductible** waived. Member may be responsible for any costs above the allowed amount for a Non-PPO provider.
	Emergency medical transportation	**10%** Coinsurance	**10%** Coinsurance	--------none--------
	Urgent care	**$50** Copay/Visit	**40%** Coinsurance	**Deductible** waived for PPO provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	**$500** Copay/Admission then **40%** Coinsurance	Subject to utlization review for inpatient and certain outpatient services at all facilities; waived for emergency admissions.
	Physician/surgeon fee	**10%** Coinsurance	**40%** Coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit **$15** Copay/Visit Mental/Behavioral Health Facility Visit - Facility Charges **10%** Coinsurance	Mental/Behavioral Health Office Visit **40%** Coinsurance Mental/Behavioral Health Facility Visit - Facility Charges **40%** Coinsurance	**Deductible** waived for PPO Provider physician outpatient visits
	Mental/Behavioral health inpatient services	**10%** Coinsurance	**40%** Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance use disorder outpatient services	Substance Abuse Office Visit **$15** Copay/Visit Substance Abuse Facility Visit - Facility Charges **10%** Coinsurance	Substance Abuse Office Visit **40%** Coinsurance Substance Abuse Facility Visit - Facility Charges **40%** Coinsurance	**Deductible** waived for PPO Provider physician outpatient visits
	Substance use disorder inpatient services	**10%** Coinsurance	**40%** Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	**10%** Coinsurance	**40%** Coinsurance	Prenatal preventive office visits, preventive lab, and ultrasound are covered 100%.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Delivery and all inpatient services	**10%** Coinsurance	**$500** Copay/Admission then **40%** Coinsurance	--------none--------
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 100 visits per Benefit Period, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care.
	Rehabilitation services	**$15** Copay/Visit	**40%** Coinsurance	Coverage is limited to 24 visits per Benefit Period for Physical Therapy, Physical Medicine and Occupational Therapy; additional visits may be authorized. Services from PPO and Non-PPO Provider count towards your limit.
	Habilitation services	**$15** Copay/Visit	**40%** Coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to 100 days per Benefit Period.
	Durable medical equipment	**10%** Coinsurance	**40%** Coinsurance	--------none--------
	Hospice service	**0%** Coinsurance	**0%** Coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	No Cost Share	No Cost Share	Coverage for PPO and Non-PPO is limited to one exam per Benefit Period. Limited reimbursement for Non-PPO Providers.
	Glasses	No Cost Share	No Cost Share	Coverage for PPO and Non-PPO is limited to 1 unit per Benefit Period. Limited reimbursement for Non-PPO Providers.
	Dental check-up	**0%** Coinsurance	**0%** Coinsurance	Coverage for PPO and Non-PPO is limited to one visit every 6 months.

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)
- Infertility treatment
- 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, consult your formal contract of coverage.)
- Chiropractic care
- Hearing aids (Coverage is limited to one hearing aid per ear every three years.)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

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:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

California Department of Insurance
Consumer Communications Bureau Health Unit
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)
(800) 482-4833 TDD
www.insurance.ca.gov

A consumer assistance program can help you file your appeal. Contact:
Consumer Communications Bureau Health Unit
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)
(800) 482-4833 TDD
www.insurance.ca.gov

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:

Spanish (Español): Para obtener asistencia en Español, llame al 866-940-8306.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-940-8306.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 866-940-8306.

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:

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:** $6,380
- **Patient pays:** $1,160

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	$300
Copays	$10
Coinsurance	$700
Limits or exclusions	$150
Total	**$1,160**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,550
- **Patient pays:** $850

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	$300
Copays	$350
Coinsurance	$120
Limits or exclusions	$80
Total	**$850**

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**, **copayments**, 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.