Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Anthem Blue Cross Life and Health Insurance Company:
University of San Francisco: Custom Anthem PPO HSA Embedded 4500 25/50

Coverage Period: 01/01/2019– 12/31/2019
Coverage for: Individual + Family | Plan Type: CDHP

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, https://eoc.anthem.com/eocdps/ca/aso. 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 (855) 333-5730 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>$4,500/individual member or $9,000/family for In-Network Providers. $9,000/individual member or $18,000/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 In-Network Providers.</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>$6,550/individual member or $13,100/family for In-Network Providers. $13,100/individual member or $26,200/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, 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, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730 for a list of network providers.</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). 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.</td>
</tr>
</tbody>
</table>
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>In-Network Provider (You will pay the least)</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>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>------none-------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>------none-------</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>------none-------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>$800 maximum/procedure for Out-of-Network Providers.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>25% coinsurance (retail) and 50% coinsurance (home delivery)</td>
<td>50% coinsurance (retail) of the prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</td>
<td>Most home delivery is 90-day supply. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred / Brand</td>
<td>25% coinsurance (retail) and 50% coinsurance (home delivery)</td>
<td>50% coinsurance (retail) of the prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs</td>
<td>25% coinsurance (retail) and 50% coinsurance (home delivery)</td>
<td>50% coinsurance (retail) of the prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>25% coinsurance (retail) and 50% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.
<table>
<thead>
<tr>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit</td>
<td>Office Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient</td>
<td>Other Outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need inpatient services</td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

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### Common Medical Event

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<tr>
<td><strong>In-Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Hospice services
- 25% coinsurance
- 50% coinsurance

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#### If your child needs dental or eye care
- **Children’s eye exam**: Not covered
- **Children’s glasses**: Not covered
- **Children’s dental check-up**: Not covered

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#### 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
- Infertility treatment
- Routine eye care (adult)
- Dental care (adult)
- Glasses for a child
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental Check-up
- Hearing aids
- Private-duty nursing
- Weight loss programs

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

- Abortion
- Chiropractic care 30 visits/benefit period.
- Acupuncture 20 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery for In-Network Providers.

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* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/ca/aso](https://eoc.anthem.com/eocdps/ca/aso).
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
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform
California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), www.insurance.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes/No
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 Standards? Yes/No
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 https://eoc.anthem.com/eocdps/ca/aso.
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: $4,500
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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**: $12,800

**In this example, Peg would pay**:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,100</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: $6,660

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

- The plan’s overall deductible: $4,500
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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**: $7,400

**In this example, Joe would pay**:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$4,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Joe would pay is: $6,360

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

- The plan’s overall deductible: $4,500
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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**: $1,900

**In this example, Mia would pay**:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: $1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 (855) 333-5730.

**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 (855) 333-5730.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અને આપની હોંપેન્નો હોય તો, હોં પણ વગર આપની ભાષામાં મહત અને માલિકી મિજાગાઓ તમને અદિકર છે. તેમજ સાથે વાત કરવા માટે, કોલ કરો (855) 333-5730.

**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 (855) 333-5730.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निष्पक्ष अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। तुम्हें यह सेवा भी मिलेगी, कॉल करें (855) 333-5730।

**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 (855) 333-5730.

**Igbo (Igbo):** Ọ bụrụ na i nwere ajụjụ ọ bula gbasara akwụkwọ a, i nwere ikike ìnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bula. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5730.

**Ilokano (Ilokano):** Nu addaan ka iti animan 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 (855) 333-5730.

**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 (855) 333-5730.

**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 (855) 333-5730.

**Japanese (日本語):** この文書について何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援を受け情報を得る権利があります。通訳と話すには、(855) 333-5730 にお電話ください。
Language Access Services:

Khmer (ខ្មែរ): ប្រយោគត្រង់សម្រាប់យើងបានបង្កើតដោយជាការប្រឈមប្រាយអំពីការប្រឈមប្រាយអំពីប្រយោគបានបង្កើតដោយជាការប្រឈមប្រាយអំពីប្រយោគ។ ងាររក្សាទូរស័ព្ទ (855) 333-5730 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 333-5730.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5730 로 문의하십시오.

Lao (ລາວ): ផ្លូវការពីអ្នកដែលឆ្លាស់ប្លង់ភាសាខ្មែរមានអាហារនេះ, អ្នកគួរតែទៅកំណត់ពីមូលហ៍របស់របស់អ្នកដោយដាក់ប្រយោគបានបង្កើតដោយជាការប្រឈមប្រាយអំពីប្រយោគ។ ងាររក្សាទូរស័ព្ទ (855) 333-5730.

Navajo (Dine'): Dií naaltsoos biká’ígii łahgo bina’idilkidgo ná bohónéedzá dóó bee ahó’t’i’ t’áá ni nizaaad k’ehjí bee nił hodoonih t’áadoo báah ilinígóó. Ata’ halne’ígii la’ bichjí’ hadeeszhí ninizingo koji’ hodíilnih (855) 333-5730.

Nepali (नेपाली): यदि आपको इस डॉ档मेंट के बारे में कोई सवाल है, तो आप अपनी भाषा में मदद और जानकारी का अधिकार रखते हैं। शरीक की मदद के लिए (855) 333-5730 को जनसंभोग की मदद के लिए (855) 333-5730.

Oromo (Oromiffa): Sanadi kanaa wajii walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeuffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 333-5730 bilbilla.


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