UNIVERSITY OF CALIFORNIA

STUDENT HEALTH INSURANCE PLAN (UC SHIP)

August 1, 2015

Blue View Vision[SM] Plan

CERTIFICATE OF INSURANCE

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, California 91367

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your vision plan. It replaces any older certificates issued to you for the coverage described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Certificate of Insurance that apply to those needs. Your campus student health and counseling services will provide you with a copy of the Group Policy upon request.

Your vision care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your vision care benefits and include the limitations and all other *policy* provisions which apply to you. The *insured person* is referred to as "you" or "your," and Anthem Blue Cross Life and Health as "we," "us" or "our." All italicized words have specific *policy* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage, you may contact us at:

Anthem Blue Cross Life and Health Insurance Company
Customer Service
21555 Oxnard Street
Woodland Hills, CA 91367

818-234-2700

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013

1-800-927-HELP (4357) – In California
1-213-897-8921 – Out of California
1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: "Consumer Services" link at www.insurance.ca.gov

Complaints or disputes relating to eligibility for coverage under the plan should be directed to your campus student health and counseling services, in writing, within 60 days of the notification that you are not eligible for coverage. You should include all information and documentation on which your grievance is based. The student health and counseling services will notify you in writing of its conclusion regarding your eligibility. If the student health and counseling services confirms the determination that you are ineligible, you may request, in writing, that the UC Student Health Insurance Plan (UC SHIP) office review this decision. Your request for review should be sent within 60 days after receipt of the notice from the student health and counseling services (confirming your ineligibility) and should include all information and documentation relevant to your grievance. Your request for review should be directed to: University of California Student Health Insurance Plan, Risk Services, 1111 Franklin Street, 10th Floor, Oakland, CA 94607. The decision of the UC SHIP office will be final.

UC SHIP Customer Service Number: 1-866-940-8306

UC SHIP website: www.ucop.edu/ucship

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BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *policy*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *insured person* and Anthem Blue Cross Life and Health agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The *insured person* and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the *insured person* waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the *insured person*.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the *insured person* making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *insured person* and Anthem Blue Cross Life and Health, or by order of the court, if the *insured person* and Anthem Blue Cross Life and Health cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department listed on your identification card.

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HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

Insured Students

1. The following classes of students are automatically enrolled as *insured students*:

   a. All registered graduate students of the following University of California campuses:

      i. Davis
      ii. Hastings College of the Law
      iii. Irvine
      iv. Los Angeles
      v. Merced
      vi. San Diego
      vii. San Francisco
      viii. Santa Cruz

   b. All registered undergraduate students of the following University of California campuses:

      i. Davis
      ii. Irvine
      iii. Los Angeles
      iv. Merced
      v. Santa Cruz

   c. All graduate students of the University of California campuses listed in 1.a. who are registered in-absentia.

   d. Individuals on the UC San Francisco campus enrolled in the "Scholars and Researchers Health Plan" which encompasses persons who are non-registered students, but are scholars and/or researchers engaged in a program or academic pursuit approved or recognized by the campus. Each enrollee must present official approval from a campus representative of the program.

   Note: A student may waive mandatory enrollment in UC SHIP (medical/dental/vision) during the waiver period specified by his or her home campus by providing proof of other medical coverage that meets benefit criteria specified by the University. A waiver is effective for one academic year and must be completed again during the

waiver period at the start of each fall quarter or semester. Waiver requests for each academic term within a year (Winter or Spring quarter or semester) are also available. Information about waiving enrollment in UC SHIP may be obtained from the student health and counseling services on campus.

2. The following classes of individuals may enroll voluntarily as *insured students*:

   a. All registered undergraduate students of the University of California at San Diego who are enrolled in UC SHIP's medical coverage.

   b. All non-registered "Filing Fee" status graduate students of the University of California campuses at Davis, Irvine, Los Angeles, Merced, San Diego, San Francisco, and Santa Cruz, who are completing work under the auspices of the University of California but are not attending classes. Students on Filing Fee status may purchase *plan* coverage for a maximum of one semester or one quarter by contacting Wells Fargo Insurance Services at 800-853-5899. The student must have been registered at the University and covered by the *plan* in the term immediately preceding the term the student wants to purchase coverage or, if the student waived plan enrollment, show proof of loss of the coverage used to obtain the waiver.

   c. All non-registered graduate students of the University of California campuses at Davis, Irvine, Los Angeles, Merced, San Diego, San Francisco, and Santa Cruz who are on Planned Educational Leave or Approved Leave of Absence status; and non-registered undergraduate students who are on a Planned Educational Leave or an Approved Leave of Absence on the campuses of Davis, Merced, and Santa Cruz. These students may purchase *plan* coverage for a maximum of one semester or two quarters. The student must have been registered at the University and covered by the *plan* in the term immediately preceding the term the student wants to purchase coverage or, if the student waived plan enrollment, show proof of loss of the coverage used to obtain the waiver. These students may enroll by contacting Wells Fargo Insurance Services at 800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST.

   d. All former students of the University of California campuses listed in 1. and 2.a.and b. above who were covered under the *plan* and completed their degree (graduated) during the term immediately preceding the term for which they want to purchase coverage. These individuals may purchase *Plan* coverage for a maximum of one semester or one quarter. Enroll by contacting

Wells Fargo Insurance Services at 800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST.

Insured Dependents

1. The following classes of dependents of *insured students* may enroll voluntarily in the *plan*:

   a. *Spouse*: Legally married *spouse* of the *insured student*.

   b. *Domestic Partner*: The individual designated as an *insured student's* domestic partner under one of the following methods: (i) registration of the partnership with the State of California; (ii) establishment of a same-sex legal union, other than marriage, formed in another jurisdiction that is substantially equivalent to a State of California-registered domestic partnership; or (iii) filing of a Declaration of Domestic Partnership form with the University. An insured student's opposite-sex domestic partner will be eligible for coverage only if one or both partners are age 62 or over and eligible for Social Security benefits based on age.

   c. *Child*: The *insured student's*:

      – Biological *child* under the age of 26

      – Stepchild: A stepchild under the age of 26 is a dependent as of the date the *insured student* marries the *child's* parent.

      – Adopted *child* under the age of 26, including a *child* placed with the *insured student* or the *insured student's spouse* or *domestic partner,* for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

      – *Child* of the *insured student's domestic partner*: A *child* of the *insured student's domestic partner* under the age of 26 is a dependent as of the effective date of the domestic partnership.

      – Foster Child: A foster *child* under the age of 18 is a dependent from the moment of placement with the *insured student* as certified by the agency making the placement. In certain circumstances, the foster child age limit may be extended in accordance with the provision for a nonminor dependent, as defined in the California Welfare and Institutions Code Section 11400 (v).

- Dependent Adult Child: An unmarried child who is 26 years of age or more and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *student, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. The University may request proof of these conditions in order to continue coverage. The University must receive the certification, at no expense to the University, within 60 days of the date the *student* receives the request. The University may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

  NOTE: If both student parents or *domestic partners* are covered as *insured students*, their children may be covered as the *dependents* of either, but not of both.

2. Students are required to provide proof of dependent status when enrolling their dependents in the *plan*. The following documents will be accepted:

   a. For *spouse*, a marriage certificate

   b. For a *domestic partner*, a Declaration of Domestic Partnership issued by the State of California, or of same-sex legal union other than marriage formed in another jurisdiction, or a completed Declaration of Domestic Partnership form issued by the University

   c. For biological *child*, a birth certificate showing the student is the parent of the *child*

   d. For stepchild, a birth certificate, and a marriage certificate showing that one of the parents listed on the birth certificate is married to the student

   e. For a biological *child* of a *domestic partner*, a birth certificate showing the domestic partner is the parent of the *child*

f. For adopted or foster *child*, documentation from the placement agency showing that the student or the *domestic partner* has the legal right to control the *child's* health care

PERIODS OF COVERAGE

Dates of coverage vary by the campus and program in which the student is enrolled. Please contact the student health and counseling services for information on coverage periods.

ENROLLMENT

We do not require written applications from registered students. The University of California will maintain records of all students registered in each academic semester/quarter and will enroll all registered students, other than those who provide proof that they have other medical coverage that meets criteria established by the University, for coverage under this *plan* in each academic semester/quarter for which they are registered.

Students who lose their other health coverage during the coverage period must notify the student health and counseling services with an official written letter of termination from the previous health insurance carrier. Students will be enrolled in the *plan* as of the date of their loss of other coverage if they notify the student health and counseling services within 31 days of the loss of their coverage. If the student does not notify the student health and counseling services within the 31 days, coverage will be effective on the date the student pays the full premium. The premium is not pro-rated for enrollment occurring after the start of a coverage period.

Registered undergraduate students of the University of California at San Diego, non-registered students who enroll on a voluntary basis, and *dependents* of students must submit an enrollment application for each term of coverage. Call Wells Fargo at **800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST for enrollment information**. Enrollment applications must be received within the enrollment period dates for the term of coverage, which vary by coverage period. Enrollment will not be continued to the next coverage period unless a new application is received.

Dependents of students may be enrolled, outside of an enrollment period for a particular coverage period, within 31 calendar days of the following events:

1. For *spouse*, the date of issuance of the marriage certificate.

2. For a *domestic partner*, the date of the Declaration of Domestic Partnership issued by the State of California, or same-sex legal union other than marriage formed in another jurisdiction, or the date the completed Declaration of Domestic Partnership form issued by the University is received by the student health and counseling services.

3. For biological *child*, the date of birth.

4. For adopted or foster *child*, the date of placement with the student or *domestic partner*.

5. For any dependent, the date of loss of other coverage. An official letter of termination from the insurance carrier must be provided at the time of enrollment in UC SHIP.

All registered undergraduate students of the University of California at San Diego, non-registered students, and dependents enroll by contacting Wells Fargo Insurance Services at 800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST.

HOW COVERAGE ENDS

For students, coverage ends as provided below:

1. If the *plan* terminates, the student's coverage ends at the same time. This *plan* may be canceled or changed at any time without notice. If the *plan* terminates or changes, an *insured student* will remain covered for claims incurred but not filed or paid prior to *plan* termination or change.

2. If the *plan* no longer provides coverage for the class of students to which an *insured student* belongs, the student's coverage ends on the effective date of that change.

3. If the student graduates from the University, the student's coverage continues through the last day of the coverage period during which the student graduates from the University.

4. If the student withdraws or is dismissed from the University, whether or not coverage will be continued after the date of the withdrawal or dismissal will be determined by campus policy. Contact the student health and counseling services for more information.

5. Enrollment in the *plan* may be terminated for the reasons listed below. The student shall be notified in writing of the termination. Termination shall be effective no less than 30 days following the date of the written notice.

   a. The student is disruptive, unruly or abusive to the extent that the ability of the student health and counseling services to provide services to the student and other clients is seriously impaired, or the student fails to maintain a satisfactory provider-patient relationship after we and the student health and counseling services have made all reasonable efforts to promote such a relationship.

   b. The student knowingly gives us or the student health and counseling services incorrect or incomplete information in any document or fails to notify us of changes in his or her status that may affect eligibility for benefits.

   c. The student knowingly misrepresents plan enrollment status or coverage.

   d. The student knowingly presents an invalid prescription.

   e. The student knowingly misuses or allows the misuse of the *plan* identification card.

f. The student fails to pay any premium amount due within the time specified in writing. A student terminated for nonpayment may be re-enrolled in the *plan* upon full payment of all amounts due.

Important: If a marriage or domestic partnership terminates, or if a covered *child* loses dependent child status, the student must give or send Wells Fargo Insurance Services written notice of the termination and loss of eligibility status. Coverage for a former *spouse* or *domestic partner*, or dependent *child*, if any, ends according to the "Eligible Status" provisions. If we suffer a loss because the student fails to notify Wells Fargo Insurance Services of the termination of their marriage or domestic partnership, or of the loss of a *child's* dependent status, we may seek recovery from the student for any actual loss resulting thereby. Failure to provide written notice to Wells Fargo Insurance Services will not delay or prevent termination of coverage for the *spouse, domestic partner* or *child*. If the student notifies Wells Fargo Insurance Services in writing to cancel coverage for a former *spouse, domestic partner* or *child*, if any, immediately upon termination of the student's marriage, domestic partnership or the *child's* loss of dependent child status, such notice will be considered in compliance with the requirements of this provision.

Contact Wells Fargo Insurance Services at 800-853-5899, Monday through Friday,8:30 a.m. to 5:00 p.m. PST.

The Director of UC SHIP is responsible for the final decision on termination of enrollment in the *plan*.

For dependents, coverage ends when the student's coverage ends or the dependent no longer meets the dependent eligibility requirements, whichever occurs first.

Enrollment in the *plan* may not be terminated on the basis of sex, race, color, religion, sexual orientation, ancestry, national origin, physical disability or disease status.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS VISION CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Vision Care Providers. Anthem Blue Cross Life and Health has contracted with various *vision care providers*, including vision clinics on some campuses, to provide a network of "Participating Vision Care Providers." These providers are called "participating" because they have agreed to participate in our participating provider program, which we call Blue View Vision Insight. They have agreed to provide *insured persons* with vision care at a negotiated fee. The amount of benefits payable under this *plan* will be different for *non-participating vision care providers* than for *participating vision care providers*.

To find a participating Blue View Vision Insight vision care provider, you may call us at the customer service number listed on your ID card or you may also search for a *participating vision care provider* using the "Provider Finder" function on our website at **www.ucop.edu/ucship**.

Non-Participating Vision Care Providers. *Non-participating vision care providers* are providers which have not agreed to participate in our network. They have not agreed to the *negotiated rates* and other provisions. You will be responsible for any amounts they charge which exceed the Vision Care Benefit Maximum.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH ARE SPECIFIED IN THIS CERTIFICATE AS COVERED SERVICES. THE FACT THAT YOUR VISION CARE PROVIDER PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT A COVERED SERVICE OR A COVERED VISION EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

VISION CARE BENEFITS

Your vision care benefits cover eye examinations and eyewear only. You can choose to have your eyewear services provided by *participating vision care providers* or by *non-participating vision care providers;* however, your benefits will be affected by this choice.

CO-PAYMENTS

Participating Vision Care Provider Co-Payments

- Comprehensive vision exam **$10**
- Frames.. **No co-payment**
- Lenses – standard plastic single, bifocal, or trifocal vision (one pair) **$25**
- Contact lenses .... **No co-payment**

Note: In addition to the Co-Payment shown above, you will be required to pay any amount in excess of the vision care benefit maximums for vision care services. But, when you go to a *participating vision care provider*, your cost for vision care services and supplies in excess of the benefit maximum will be at discounted prices.

Non-Participating Vision Care Provider Co-Payments. There will be no co-payment required for services and supplies provided by a *non-participating vision care provider*, but you will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

VISION CARE BENEFIT MAXIMUMS

We will pay benefits for the following services and materials, up to the maximum dollar amounts and benefit periods shown below:

Participating Vision Care Provider

- Comprehensive vision exam .... **Covered in full** after copay one exam per *benefit year*
- Frames.. **$120.00** plus **20%** of remaining balance, limited to one frame per *benefit year*
- Prescription lenses .... one pair per *benefit year*
  - Single vision lenses.. **Covered in full** after copay
  - Bi-focal lenses.. **Covered in full** after copay
  - Tri-focal lenses... **Covered in full** after copay
- Non-elective contact lenses.. **Covered in full** once per *benefit year*
- Elective conventional contact lenses* .... **$120.00** then **15%** of remaining balance, limited to once per *benefit year*
- Elective disposable contact lenses* .... **$120.00** limited to once per *benefit year*

* Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a *benefit year*, we will not pay benefits for eyeglass lenses during that same *benefit year*.

Non-Participating Vision Care Provider

- Comprehensive vision exam .... **$49.00** one exam per *benefit year*
- Frames... **$50.00** one frame per *benefit year*
- Prescription lenses .... one pair per *benefit year*

- – Single vision lenses **$35.00**
- – Bi-focal lenses **$49.00**
- – Tri-focal lenses **$74.00**

- Non-elective contact lenses **$250.00**
  once per *benefit year*
- Elective conventional contact lenses* **$92.00**
  once per *benefit year*
- Elective disposable contact lenses* **$92.00**
  once per *benefit year*

* Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a *benefit year*, we will not pay benefits for eyeglass lenses during that same *benefit year*.

GENERAL INFORMATION

Contributions–The insurance for you and your *dependents* is *contributory insurance*. You will be informed of the amount of your contribution (premium) when you enroll.

Anthem Blue Cross Life and Health's Address–

Anthem Blue Cross Life and Health Insurance Company
Group Services
P.O. Box 70000
Van Nuys, California 91470

YOUR VISION CARE BENEFITS

HOW COVERED VISION EXPENSE IS DETERMINED

Covered vision expense is based on a maximum charge for each covered service or materials which we will accept. It is not necessarily the amount a vision care provider bills for the service. A vision care expense is incurred on the date you receive the service or materials for which the charge is made.

Participating Vision Care Providers. The maximum *covered vision expense* for services provided by a *participating vision care provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating vision care providers* have agreed not to charge you more than the *negotiated rate* for covered services.

If you choose frames or lenses that cost more than the Vision Care Benefit Maximum, you will pay the excess at a discounted price. If you choose vision options that are not covered under this *plan,* you will be charged a discounted price.

Non-Participating Vision Care Providers. The maximum *covered vision expense* for services provided by a *non-participating vision care provider* will always be the lesser of the billed charge or the Vision Care Benefit Maximum shown in the SUMMARY OF BENEFITS. You will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

You will always be responsible for expense incurred which is not covered under this *plan*.

VISION CARE CO-PAYMENTS AND BENEFIT MAXIMUMS

After we subtract your Co-Payment, we will pay benefits up to the amount of *covered vision expense,* not to exceed the applicable Vision Care Benefit Maximum. The Co-Payments and Vision Care Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR VISION CARE BENEFITS

When You Go to a Participating Vision Care Provider. To identify you as an insured covered for vision care benefits, you will be issued an identification card. You must present this card to *participating vision care providers* (which includes your on-campus vision clinic, if any) when you go for your appointment. A *participating vision care provider* will only charge your Co-Payment and any charges in excess of the Vision Care Benefit Maximum. When a *participating vision care provider* bills us for covered services, we will pay them directly.

When You Go to a Non-Participating Vision Care Provider. If you go to a *non-participating vision care provider* for services, you will have to pay the full cost of the eye examination and/or for any lenses or frames you purchase. You should make copies of the bills for your own records and attach the original bills to the receipt. Send the receipt with your ID number, at the address below:

Anthem Blue Cross Life and Health Insurance Company
Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111

You must send your receipt from the *vision care provider* with your ID number within 90 days of the date of exam and/or purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered vision expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or materials for which the charge is made.
2. The expense must be for a routine care of the eye, not for surgery or medical care.
3. The expense must be for a vision service or materials included in VISION CARE THAT IS COVERED. Additional limits on *covered vision expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a vision service or materials listed in VISION CARE THAT IS NOT COVERED. If the service or materials are partially excluded, then only that portion which is not excluded will be considered *covered vision expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. All services and materials must be ordered by a licensed ophthalmologist, optometrist or dispensing optician.

VISION CARE THAT IS COVERED

Subject to the Vision Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under VISION CARE THAT IS NOT COVERED, we will provide benefits for the following services and materials:

Vision Examination. A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of correction eyewear where indicated. This does not include a contact lens fitting fee.

Frames. The *vision care provider* will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. If you go to a *participating vision care provider* and you choose frames that cost more than the benefit maximum shown under SUMMARY OF BENEFITS: VISION CARE BENEFIT MAXIMUMS, your cost will be based on a discounted arrangement.

Lenses. The *vision care provider* will order the proper lenses necessary for your visual welfare. The *vision care provider* will verify the accuracy of the finished lenses. Covered lenses include plastic (CR39):

1. Single vision;
2. Bifocal; or
3. Trifocal (FT25-28).

Benefits include factory scratch coating. Photochromic and polycarbonate lenses prescribed for anyone age 19 and under are covered in full.

We will not pay for: (a) Progressive lenses; and (b) all other coating, other lens materials and treatments not listed above.

You will be responsible for amounts in excess of the Vision Care Benefit Maximum.

Elective Contact Lenses. You have an allowance per *benefit year* toward cosmetic contact lenses selected in lieu of the eyeglass lens benefit. If you choose contact lenses that cost more than the *plan* allowance, you are responsible for the difference in cost. If you choose to receive contact lenses during a *benefit year*, no benefits will be paid for lenses during that same *benefit year*.

Non-Elective Contact Lenses. Non-elective lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit per *benefit year*. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

1. Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
2. Keratoconus - unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
3. High Ametropia - unusually high levels of near sightedness, far sightedness, or
4. Anisometropia - when one eye requires a much different prescription than the other eye.

VISION CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Experimental or Investigative. Any *experimental* or *investigative* services or materials.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Uninsured. Services received before your *effective date* or after your coverage ends.

Non-Licensed Vision Care Providers. Treatment or services rendered by non-licensed *vision care providers* and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed *vision care provider* under the supervision of a licensed physician or licensed *vision care provider*, except as specifically provided or arranged by us.

Excess Amounts. Any amounts in excess of *covered vision expense*.

Routine Exams or Tests. Routine examinations required by an employer in connection with your employment.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

Government Treatment. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

Services of Relatives. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *insured person* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Sunglasses. Sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Hospital Care. Inpatient or outpatient hospital vision care.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Cosmetic Options. Blended lenses/no line; oversize lenses; progressive multifocal lenses; photochromatic lens; tinted lenses, except as specifically stated in the "lenses" provision of VISION CARE THAT IS COVERED; coated lenses, except factory scratch coating; cosmetic lenses or processes; and UV-protected lenses.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames, unless you have reached a new *benefit year*.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of vision care, nor are we responsible for the quality of any such care received.

Independent Contractors. Our relationship with providers is that of an independent contractor. Opthalmologists, optometrists and dispensing opticians are not our agents nor are we or any of our employees, an employee or agent of any *vision care provider* of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of vision care, except to the extent that rates for covered services are regulated with *participating vision care providers*.

Terms of Coverage

1. In order for you to be entitled to benefits under the *policy,* both the *policy* and your coverage under the *policy* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The *policy* is subject to amendment, modification or termination according to the provisions of the *policy* without your consent or concurrence.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your premiums are paid according to the terms of the *policy*, except as noted in HOW COVERAGE ENDS.

Free Choice of Provider. This *plan* in no way interferes with your right as an *insured person* entitled to vision care benefits to select a *vision care provider.* You may choose any *vision care provider* which provides care covered under this *plan,* and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim and Proof of Loss. You or the *vision care provider* must send us an itemized bill within 90 days of the date you receive the service or supply for which claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time. Canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this *plan* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

Payment to Providers. We will pay the benefits of this *plan* directly to *participating vision care providers*. Also, we will pay *non-participating vision care providers* directly when you assign benefits in writing. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount.

We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

Workers' Compensation Insurance. The *policy* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Entire Contract. This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverage described in the Summary of Benefits. All benefits are subject in every way to the entire *policy* which includes this certificate. The terms of the *policy* may be changed only by a written endorsement signed by one of our authorized officers and accepted by the University. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *policy*.

Liability For Statements. No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *policy*. Statements made by you will not be deemed warranties. No statement made by you will be used by us to contest a claim, unless such a statement appears in a written form signed by you, and we have furnished a copy of that form to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

Physical Examination. At our expense, we have the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

Legal Actions. No attempt to recover on the *plan* through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this *plan*. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Conformity with Laws. Any provision of the *policy* which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Financial Arrangements with Providers. Under arrangements with some health care providers and suppliers (hereafter referred to together as "Providers") certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, vision services rebates, may be based on utilization of specific Providers for specified vision services rendered to all persons who have coverage through a similar vision program provided or administered by Anthem Blue Cross Life and Health or an affiliate. They are not attributed to

specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

DEFINITIONS

The meanings of key terms used in this certificate are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your certificate, you should refer to this section.

Benefit year is a 12-month period that determines the application of your benefits, such as the accumulation toward satisfaction of the annual deductible and accumulation toward annual benefit limitations or maximums. Your benefit year starts at the first of the month in which your coverage period begins.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Contributory Insurance; non-contributory insurance. Contributory insurance is insurance for which the *group* has the right to require your contributions. Non-contributory insurance is insurance for which the *group* does not have the right to require your contributions. The Summary of Benefits shows whether insurance under a coverage is *contributory insurance* or *non-contributory insurance*.

Coverage period is the period during which a student and his or her dependents are eligible for coverage and receive the benefits of this *plan.*

Covered vision expense is the expense you incur for a covered service or materials, but not more than the maximum amounts described in YOUR VISION CARE BENEFITS: HOW COVERED VISION EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or materials.

Dependent meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS.

Effective date is the date your coverage begins under this *plan*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Group refers to the entity to which we have issued this *policy*. The name of the group is the UNIVERSITY OF CALIFORNIA STUDENT HEALTH INSURANCE PLAN.

Insured person is the *insured student* or *insured dependent*.

Insured student (student) is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *dependents*.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Negotiated rate is the amount *participating vision care providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Preferred Provider Organization Plan Participating Agreements.

Non-participating vision care provider is a provider which does not have a Preferred Provider Agreement with us at the time services are rendered.

Participating vision care provider is a provider which has a Preferred Provider Organization Plan Participating Agreement in effect with us at the time services are rendered. Participating vision care providers agree to accept the *negotiated rate* as payment in full for covered services.

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the *policy* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *insured student* affected by the change.

Plan year is the start and end date of the UC SHIP plan, used for the purposes of the plan contract, financial management and data reporting.

Policy is the Group Policy we have issued to the *group*.

Prior plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Vision care provider is an ophthalmologist, optometrist or dispensing optician who is licensed to practice vision care, is rendering a service within the scope of the license and is providing a service for which benefits are specified in this booklet.

We (us, our) refers to Anthem Blue Cross Life and Health Insurance Company or Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health).

You (your) refers to the *insured student* and *dependents* who are enrolled for benefits under this *plan*.