University of California Student Health Insurance Plan (UC SHIP)
UCSF Dependent Medical, Behavioral Health and Pharmacy Plan

Coverage Period: 2014-15 Plan Year

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Dependent **Plan Type:** Custom EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Benefit Booklet at www.ucop.edu/ucship or by calling 1-866-940-8306. Adult dependents must seek non-emergency services from the Student Health & Counseling Services (SHCS) on campus; referrals to Anthem's network are provided if care outside the SHCS is needed. Dependent children are required to access care from network providers.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$400 per member** Does not apply to In-Network Preventive Care or Prescription Drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your Benefit Booklet to see when the **deductible** starts over. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	----------None----------
Is there an out–of–pocket limit on my expenses?	Yes, In-Network Provider per member: **$6,000**	The **out-of-pocket limit** is the most you could pay in coinsurance and copayments during a coverage period (usually 12 months) 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?	Balance-billed charges, health care premiums, and charges for services that are not covered by this plan.	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. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes, See www.anthem.com/ca or call **1-866-940-8306** for a list of Participating 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. If you obtain services at a UC Health System hospital or professional provider, you will receive a UC SHIP discount. Most UC providers are in the Anthem Blue Cross network, but check to verify network status before your appointment. Be aware, you must use an In-Network doctor or hospital, except for emergency services. Plans use the term In-Network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**. See the Benefit Booklet "Definitions" section for more information.
Do I need a referral to see a specialist?	Adult dependents are required to obtain a referral from the Student Health & Counseling Services at UCSF. Children do not require a referral.	Adult dependents must seek care at the Student Health & Counseling Services prior to seeking care with an In-Network provider. The Student Health & Counseling Services will provide a referral to seek services outside of the Student Health & Counseling Services. This plan will pay some or all of the costs to see a specialist for covered services, but only if you are treated by a participating provider.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 11. See your Benefit Booklet 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 percentage 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** determined by Anthem Blue Cross.
- This plan requires you to use an **In-Network Provider** or **"Other health care provider"** as defined in the Benefit Booklet. These providers have a contractual agreement with Anthem Blue Cross.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**20% Coinsurance**	**Not covered**	Services must be performed by an Anthem PPO provider
	Specialist visit	**20% Coinsurance**	**Not covered**	Services must be performed by an Anthem PPO provider
	Other practitioner office visit	**Chiropractor** 20% **Coinsurance** per visit **Acupuncture** 20% **Coinsurance** per visit	**Not covered**	Chiropractor ---------None---------- Acupuncturist Coverage is limited to a total of 20 visits per Benefit Year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Preventive care/cancer screening/*immunizations/ Well-woman, Well-child, and contraceptive care	No Charge	**Not covered**	*The following is a partial list of immunizations covered at 100%: Diphtheria, Tetanus, Pertussis, Measles, Mumps, Rubella, Varicella, Influenza, Hepatitis A, Hepatitis B, Pneumococcal, Meningococcal, Polio, and Human Papillomavirus (HPV). All other immunizations are covered at 80% for In- Network Providers. Preventive care, screening and immunizations are not covered at non-Network Providers
If you have a test	Diagnostic test (x-ray, blood work)	**20% Coinsurance** for Lab and X-Ray	**Not covered**	----------None----------
	Imaging (CT/PET scans, MRIs)	**20% Coinsurance**	**Not covered**	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ventegra.net**	Generic drugs	**$5 copayment**	**Not covered**	Covers up to a 30 day supply. Not subject to the Deductible. Pharmacies are contracted with Ventegra. Please see www.ventegra.net for a list of participating providers
	Preferred brand drugs	**30% of negotiated fees**	**Not covered**	
	Non-preferred brand drugs	**30% of negotiated fees**	**Not covered**	
If you have outpatient surgery	Facility (e.g., ambulatory surgery center)	**20% Coinsurance** for members	**Not covered**	Prior authorization from Anthem Blue Cross may be required
	Physician/surgeon	**20% Coinsurance** for members	**Not covered**	Prior authorization from Anthem Blue Cross may be required
If you need immediate medical attention	Emergency room services	**$100 Copayment + 20% Coinsurance**	**$100 Copayment + 20% Coinsurance**	**Copayment** is waived if admitted as an inpatient. This is for the hospital/facility charge only. If treated at a non-participating facility, you may be responsible for charges above the allowed amount.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	**20% Coinsurance** for ground ambulance and for air ambulance	**20% Coinsurance** for ground ambulance and air ambulance	The percentage of coverage is based on billed charges.
	Urgent care	**$50 Copayment; + 20% Coinsurance**/Visit	**Not covered**	Costs may vary by site of service. You should refer to your Benefit Booklet for details.
If you have a hospital stay	Facility (e.g., hospital room)	**20% Coinsurance** for members	**Not covered**	Prior authorization from Anthem Blue Cross is required. UCSF Medical Center waives the coinsurance for inpatient services.
	Physician/surgeon	**20% Coinsurance** for members	**Not covered**	Prior authorization from Anthem Blue Cross is required. UCSF Medical Center has agreed to waive the member's **coinsurance.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health office visits and outpatient services	**20% Coinsurance**	**Not covered**	----------None----------
	Mental/Behavioral health services during a hospital stay	**20% Coinsurance**	**Not covered**	Prior authorization from Anthem Blue Cross is required
	Substance use disorder office visits and outpatient services	**20% Coinsurance**	**Not covered**	----------None----------
	Substance use disorder services during a hospital stay	**20% Coinsurance**	**Not covered**	Prior authorization from Anthem Blue Cross is required
If you are pregnant	Prenatal and postnatal care	**20% Coinsurance** for initial visit only. All other visits have no charge.	**Not covered**	----------None----------
	Delivery and all related hospital services	**20% Coinsurance** for members	**Not covered**	Prior authorization from Anthem Blue Cross is required. UCSF Medical Center waives the coinsurance for inpatient services.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20% Coinsurance**	**Not covered**	Prior authorization from Anthem Blue Cross is required
	Rehabilitation services	**20% Coinsurance**	**Not covered**	----------None----------
	Habilitation services	**20% Coinsurance**	**Not covered**	----------None----------
	Skilled nursing care	**20% Coinsurance**	**Not covered**	Prior authorization from Anthem Blue Cross is required
	Durable medical equipment	**20% Coinsurance**	**Not covered**	Prior authorization from Anthem Blue Cross is required
	Hospice service	**20% Coinsurance**	**Not covered**	Prior authorization from Anthem Blue Cross is required

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Benefit Booklet for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Erectile dysfunction medications
- Exams or tests required for participation in an academic, recreational, or employment activity
- Experimental or unnecessary medical treatment
- Infertility diagnosis & treatment
- Intercollegiate sports injuries
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care unless you have been diagnosed with diabetes. Consult your Benefit Booklet
- Services performed without a Student Health referral
- Weight Loss programs
- Work-related conditions covered by Workers Compensation

Other Covered Services (This isn't a complete list. Check your Benefit Booklet for other covered services and your costs for these services.)

- Bariatric surgery is covered only for morbid obesity
- Hearing aids (every 4 years)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide. See the UC SHIP Benefit Booklet for Medical Evacuation and Repatriation benefits

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 BlueCross
ATTN: Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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** $6960
- **Patient pays** $580

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	$400
Copayments	$60
Coinsurance	1548
Limits or exclusions	0
Total	**$2,008**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4690
- **Patient pays** $710

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	$400
Copayments	$0
Coinsurance	$1000
Limits or exclusions	$0
Total	**$1,400**

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.