University of California Student Health Insurance Plan (UC SHIP)
Student Health and Counseling Services at UC San Francisco (SHCS)

Coverage Period: 2013-2014 Plan Year

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

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200 per student** Does not apply to services at the Student Health and Counseling Services, In-Network Preventive Care services, Office Visits with a set-dollar **copayment**, or Prescription Drugs. The **deductible** applies to **In-Network Provider** and Non-Network Provider services, *combined.*	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?	Yes, a **$500** for Additional **deductible** for non-Anthem Blue Cross PPO hospital or residential treatment center or ambulatory surgical center if utilization review not obtained.	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, In-Network Provider per student: **$3,000** Non-Network Provider per Student: **$6,000**	The **out-of-pocket limit** is the most you could pay in **coinsurance** 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. In-Network and Non-Network Provider out–of–pocket limits are **not** combined. They accumulate separately.

Questions: Call 1-866-940-8306 or visit us at www.ucop.edu/ucship

If you aren't clear about any of the underlined terms used in this form, see the Glossary (pg.3). You can view the Glossary at www.anthem.com/ca or call 1-866-940-8306 to request a copy.

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Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Balance-Billed Charges, the **deductible**, Health Care This Plan Doesn't Cover, premiums, **copayments**, additional **deductibles**.	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.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes, but you must seek care at the Student Health and Counseling Services first. See www.anthem.com/ca or call **1-866-940-8306** for a list of Participating providers.	You must begin all of your care at the Student Health and Counseling Services, except in case of emergency. SHCS will provide a **referral** for care outside of the Student Health and Counseling Services if necessary. 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 3 for how this plan pays different kinds of **providers**.
Do I need a Referral to see a specialist?	Yes, you need written **Referral** from the Student Health and Counseling Services to see a specialist. There may be some providers or services for which referrals are not required. Please see Benefit Booklet for details.	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have the Student Health and Counseling Services **referral** to 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 11. See your Benefit Booklet for additional information about **excluded services**.

Glossary

- **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 10% would be $100. 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 **In-Network Provider** by charging you lower **deductibles, copayments** and **coinsurance** amounts
- A **Referral** is a written authorization given by the Student Health and Counseling Services to seek care outside of the Student Health and Counseling Services for medically necessary care.

Common Medical Event	Services You May Need	Your Cost If You Use a 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	**$15 Copayment**/Visit	**40% Coinsurance**	The insured student must obtain any non-emergency medical care from the Student Health and Counseling Services.
	Specialist visit	**$20 Copayment**/Visit	**40% Coinsurance**	The insured student must obtain a **referral** from the Student Health and Counseling Services prior to seeking care with a specialist.

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Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Other practitioner office visit	**Chiropractor** $20 **Copayment** per visit **Acupuncture** $20 **Copayment** per visit	**40% Coinsurance**	Chiropractor A **Referral** is required from the Student Health and Counseling Services prior to seeking care with a chiropractor. Acupuncturist Coverage is limited to a total of 20 visits, In-Network Provider and Non-Network Provider combined per Benefit Year. A **Referral** is required from Student Health and Counseling Services prior to seeking care from an acupuncturist.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Preventive care/cancer screening/*immunization/ Well-woman and contraceptive care	No Charge	**40% Coinsurance**	*Services are to be provided at the Student Health and Counseling Services unless the student obtains a Student Health **referral**. 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 90% In- Network Provider and 60%Non-Network Providers.
If you have a test	Diagnostic test (x-ray, blood work)	**10% Coinsurance** for Lab Office and X-Ray Office	**40% Coinsurance** for Lab Office and X-Ray Office	A **Referral** from the Student Health and Counseling Services is required.
	Imaging (CT/PET scans, MRIs)	**10% Coinsurance**	**40% Coinsurance**	A **Referral** from the Student Health and Counseling Services is required.

Common Medical Event	Services You May Need	Your Cost If You Use a 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**	**$5+any amount over the contracted rate**	Covers up to a 30 day supply
	Preferred brand drugs	**$25 Copayment**	**$25+any amount over the contracted rate**	Covers up to a 30 day supply
	Non-preferred brand drugs	**$40 Copayment**	**$40+any amount over the contracted rate**	Covers up to a 30 day supply
If you have outpatient surgery	Facility (e.g., ambulatory surgery center)	10% **Coinsurance**	**40% Coinsurance**	A **Referral** from the Student Health and Counseling Services is required. UCSF Medical Center has agreed to waive the student's annual **deductible** and **coinsurance**.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon	**10% Coinsurance**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required. UCSF physicians have agreed to waive the student's annual **deductible** and **coinsurance**.
If you need immediate medical attention	Emergency room services	**$100 Copayment**	**$100 + anything above the allowed amount.**	**Copayment** is waived if admitted inpatient. This is for the hospital/facility charge only.
	Emergency medical transportation	**10% Coinsurance** for ground ambulance/no charge for air ambulance	**10% Coinsurance** for ground ambulance/no charge for air ambulance	The percentage of coverage is based on billed charges
	Urgent care	**$50 Copayment**/Visit	**40% Coinsurance**	Costs may vary by site of service. You should refer to your Benefit Booklet for details.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility (e.g., hospital room)	**10% Coinsurance**	**40% Coinsurance**	Failure to obtain preauthorization may result in non-coverage or an additional $500 **deductible** for Non-participating providers, **waived** for emergency admissions. A **Referral** is required from the Student Health and Counseling Services for non-emergency care. UCSF Medical Center has agreed to waive the student's annual **deductible** and **coinsurance**.
	Physician/surgeon	**10% Coinsurance**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required. UCSF physician has agreed to waive the student's **coinsurance**.

Common Medical Event	Services You May Need	Your Cost If You Use a 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	**$15 Copayment** per visit for Office **10% coinsurance** for Facility	**40% Coinsurance** for Office Visit and Facility	A **Referral** from the Student Health and Counseling Services is required.
	Mental/Behavioral health services during a hospital stay	**10% Coinsurance**	**40% Coinsurance**	This is for facility professional services only. Please refer to hospital stay for facility fee. A **referral** from the Student Health and Counseling Services is required, except in an emergency.
	Substance use disorder Office Visits and outpatient services	**$15 Copayment** per visit for Office **10% coinsurance** for Facility	**40% Coinsurance** for Office Visit and Facility	A **referral** from the Student Health and Counseling Services is required.
	Substance use disorder services during a hospital stay	**10% Coinsurance**	**40% Coinsurance**	This is for facility professional services only. Please refer to hospital stay for facility fee. A **referral** from the Student Health and Counseling Services is required.
If you are pregnant	Prenatal and postnatal care	**$15 Copayment** for initial visit only. All other visits have no charge.	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Delivery and all hospital services related to delivery	**10% Coinsurance**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.
If you need help recovering or have other special health needs	Home health care	**No charge**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.
	Rehabilitation services	**$20 Copayment** per visit	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.
	Habilitation services	**$20 Copayment** per visit	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.
	Skilled nursing care	**10% Coinsurance**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.
	Durable medical equipment	**10% Coinsurance**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services is required.
	Hospice service	**10% Coinsurance**	**40% Coinsurance**	A **referral** from the Student Health and Counseling Services 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)
- Newborn coverage for 1st 31 days ($25,000 maximum)
- Psycho-educational testing
- Sex Reassignment Surgery
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide. See the UC SHIP Benefit Booklet for Medical Evacuation and Repatriation benefits

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Your Rights to Continue Coverage:

If you lose coverage under the plan, you may be eligible for Conversion to an Anthem Blue Cross Individual plan. The premium may be significantly higher than the premium you pay while covered under this plan and the benefit plan design will be different.

For more information on your rights to continue coverage, contact the plan at 1- 800-777-6000. You can review instructions for enrolling in an Anthem Blue Cross Individual Conversion plan at www.ucop.edu/ucship, click on your campus in the left navigation bar, then click on Medical Services under Online Services, and scroll down to Conversion Enrollment Information.

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

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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'ałnihí ya sidáhí bich'į naabídíiłkiid. 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	$200
Copayment	$60
Coinsurance	$320
Limits or exclusions	0
Total	**$580**

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	$200
Copayment	$330
Coinsurance	$180
Limits or exclusions	$0
Total	**$710**

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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 student 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.

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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.