**Anthem Blue Cross**  
**University of California Student Health Insurance Plan (UC SHIP)**  
**UC Merced**  
Coverage Period: 08/15/2014 – 08/14/2015  
Coverage for: Individual | Plan Type: PPO

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

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**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](http://www.ucop.edu/ucship) or by calling 1-866-940-8306.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| What is the overall deductible? | $200 deductible  
Does not apply to services provided at the Student Health Services, Preventive Care, Office Visit Copayments, and Prescription Drugs. PPO Provider and Non-PPO Provider deductibles are 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. $500/admission for non-PPO hospital or residential treatment center; waived for emergency admission. | 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? | For PPO Providers & Other Health Care Providers  
$3,000 insured person/benefit year  
For Non-PPO Providers  
$6,000 insured person/benefit year  
The maximums for PPO Providers and Non-PPO Providers are separate. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |

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If you aren’t clear about any of the underlined terms used in this form, see the Glossary, on page 3 You can view the Glossary at 1 of 12 [http://www.anthem.com/ca](http://www.anthem.com/ca) or call 1-866-940-8306 to request a copy.

*The University of California Student Health Insurance Plan is a self-funded Plan that voluntarily complies with major requirements of the Affordable Care Act.*
### Important Questions

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<tbody>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Balance-billed charges and health care premiums, and charges for services not covered under the plan.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-866-940-8306 for a list of Participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes.</td>
<td>You need written referral from a primary care physician to see a specialist. There may be some providers or services for which referrals are not required. Please see the Benefit Booklet of coverage for details.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 9. See your Benefit Booklet for additional information about excluded services.</td>
</tr>
</tbody>
</table>

### Questions:

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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 percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use PPO providers by charging you lower deductibles, copayments and coinsurance amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a PPO Provider</th>
<th>Your Cost If You Use a Non-PPO Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copayment/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 copayment/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>Chiropractor $20 copayment/visit Acupuncture $20 copayment/visit</td>
<td>Chiropractor 40% Coinsurance Acupuncture 40% Coinsurance</td>
<td>Acupuncturist Coverage is limited to a total of 20 visits In-Network Providers and Non-Network Providers combined per Benefit Year.</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Cost Share</td>
<td>40% coinsurance</td>
<td>Services are to be provided by your primary care clinician. The following partial list of immunizations are 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</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have a test</th>
<th>Diagnostic test (x-ray, blood work)</th>
<th>10% coinsurance</th>
<th>40% coinsurance</th>
<th>none</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need drugs to treat your illness or condition</th>
<th>Generic Drugs</th>
<th>$5 Copayment/prescription for retail pharmacies</th>
<th>$5 plus any amount over the contracted rate</th>
<th>Covers up to a 30 day supply. Not subject to the Deductible. Pharmacies are contracted with Ventegra. Please see <a href="http://www.ventegra.net">www.ventegra.net</a> for a list of participating pharmacies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Brand Drugs</td>
<td>$25 Copayment/prescription for retail pharmacies</td>
<td>$25 plus any amount over the contracted rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>$40 Copayment/prescription for retail pharmacies</td>
<td>$40 plus any amount over the contracted rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.ventegra.net

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<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 Copayment</td>
<td>$100 Copayment</td>
<td>Waived if admitted inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate. Member may be responsible for any costs above the allowed amount for a non-PPO provider.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>No cost for air ambulance.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copayment/ visit</td>
<td>40% coinsurance</td>
<td>Costs may vary by site of service. You should refer to your formal contract of coverage for details.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>$500/admission deductible for non-PPO hospital or residential treatment center; waived for emergency admission. Subject to utilization review for inpatient services; waived for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>10% first 48 hours, then 40% coinsurance (unless insured person can’t be moved safely)</td>
<td>——none——</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>Mental/Behavioral Health Office Visit $15 Copayment/Visit Mental/Behavioral Health Facility Visit-Facility Charges 10% Coinsurance</td>
<td>Mental/Behavioral Health Office Visit 40% Coinsurance Mental/Behavioral Health Facility Visit-Facility Charges 40% Coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td>Mental/Behavioral health inpatient services</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td>This is for facility professional services only. Please refer to your hospital stay for facility fee.</td>
</tr>
<tr>
<td>Substance abuse disorder outpatient services</td>
<td>Substance Abuse Office Visit $15 Copayment/Visit Substance Abuse Facility Visit-Facility Charges 10% Coinsurance</td>
<td>Substance Abuse Office Visit 40% Coinsurance Substance Abuse Facility Visit-Facility Charges 40% Coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td>Substance abuse disorder inpatient services</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td>This is for facility professional services only. Please refer to your hospital stay for facility fee.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care $15 Copayment/visit</td>
<td>40% Coinsurance</td>
<td>Copayment applies to initial visit only, thereafter no charge.</td>
</tr>
</tbody>
</table>

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

Common Medical Event Services You May Need Your Cost If You Use a PPO Provider Your Cost If You Use a Non-PPO Provider Limitations & Exceptions

Delivery and all inpatient services

| Coverage for: Individual | Plan Type: PPO |

Home health care No Cost Share 40% coinsurance Subject to utilization review. Limited to one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care.

Rehabilitation services $20 copayment/visit 40% coinsurance Costs may vary by site of service. You should refer to your Benefit Booklet for details.

Habilitation services $20 copayment/visit 40% coinsurance Costs may vary by site of service. You should refer to your Benefit Booklet for details.

Skilled nursing care 10% Coinsurance 40% Coinsurance Subject to utilization review.

Durable medical equipment 10% Coinsurance 40% Coinsurance ————none———

Hospice service 10% Coinsurance 40% Coinsurance ————none———

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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
- 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, except in emergency
- 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.)

- Acupuncture
- Bariatric surgery (For morbid obesity. Consult your Benefit Booklet of coverage)
- Chiropractic care
- Hearing aids (Coverage is limited to one hearing aid per ear every four years when you use a PPO provider; not covered with non-PPO providers.)
- Most coverage provided outside the United States. See [www.BCBS.com/bluecardworldwide](http://www.BCBS.com/bluecardworldwide)

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

Coverage for: Individual  |  Plan Type: PPO

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.”

This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

This health coverage does meet the minimum value standard for the benefits it provides.

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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.

如果您的孩子需要中文服务，请联系欢迎您的销售代表或小组管理人员。如果您已参保，则请使用您的ID卡上的号码联系客户服务中心。

Questions: Call 1-866-940-8306 or visit [www.ucop.edu/uchip](http://www.ucop.edu/uchip). Click to your campus homepage from the left-hand navigation bar, then click on the“Description of Benefits” link to find the Benefit Booklet.

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About these Coverage Examples:
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)
- **Amount owed to providers:** $7,540
- **Plan pays:** $6,100
- **Patient pays:** $1,440

**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 $250
- Copayments $60
- Coinsurance $980
- Limits or exclusions $150

**Total** $1,440

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays:** $4,230
- **Patient pays:** $1,170

**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 $250
- Copayments $600
- Coinsurance $240
- Limits or exclusions $80

**Total** $1,170

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