



University of California Student Health Insurance Plan (UC SHIP) Custom Dependent Medical Plan

PLEASE NOTE: This Summary of Benefits is a brief overview of medical benefits provided by UC SHIP. Pharmacy benefits are listed in a separate summary. Please refer to your Benefit Booklet which explains the full range of covered services in detail.

The coverage under this policy is secondary coverage to all other policies except Medi-Cal, MRMIP and TriCare

In addition to dollar copays and percentage coinsurance, insured persons are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Insured persons are also responsible for all costs over the plan maximums.

Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions listed in the Benefit Book, available at www.ucop.edu/ucship.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Insured persons are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers & Other Health Care Providers - The customary & reasonable charge for professional services or the reasonable charge for institutional services. **Services provided to student dependents by non-PPO providers are not a covered benefit of the plan unless services are for urgent or emergent care.**

When using permitted Non-PPO and Other Health Care Providers, insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & coinsurance.

Benefit year deductible for all providers	\$400 per insured dependent
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Annual Out-of-Pocket Maximums	
For PPO Providers	\$6,000 per insured dependent per benefit year

After an insured person reaches the out-of-pocket maximum, the insured person no longer pays coinsurance for the remainder of the plan year but remains responsible for copayments and non-covered expenses. The following do not accumulate toward out-of-pocket maximums: deductibles listed above; copayments, and non-covered expenses.

Lifetime Maximum	\$400,000 per insured dependent
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Covered Services	PPO: Per Insured Person Copay/Coinsurance
Hospital Medical Services <i>(subject to utilization review for inpatient services; waived for emergency admissions)</i> <i>The participating provider coinsurance will continue to apply to a Non-participating provider beyond the first 48 hours if you cannot be moved safely)</i>	
➤ Semi-private room, meals & special diets, & ancillary services	20%
➤ Outpatient medical care, surgical services & supplies <i>(hospital care other than emergency room care)</i>	20%
Ambulatory Surgical Centers	
➤ Outpatient surgery, services & supplies	20%
Skilled Nursing Facility <i>(subject to utilization review)</i>	
➤ Semi-private room, services & supplies <i>(limited to 100 days/benefit year)</i>	20%
Hospice Care <i>(limited to \$5,000/benefit year combined)</i>	
➤ Inpatient or outpatient services for insured persons;	20%
➤ Bereavement counseling <i>(limited to \$25 per visit; up to 4 visits in 12 months)</i>	20%
Home Health Care <i>(subject to utilization review)</i>	
➤ Services & supplies from a home health agency <i>(limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)</i>	20%
Home Infusion Therapy <i>(subject to utilization review)</i>	
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%
Physician Medical Services	
➤ Office & home visits	20%
➤ Specialists & Consultants	20%
➤ Hospital & skilled nursing facility visits	20%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	20%
Diagnostic X-ray & Lab	20%
Well Baby & Well-Child Care for Dependent Children	
➤ Routine physical examinations <i>(birth through age 18)</i>	No copay or coinsurance <i>(deductible waived)</i>
➤ Immunizations <i>(birth through age 18)</i>	No copay or coinsurance <i>(deductible waived)</i>
Physical Exams for Insured Persons Ages 19 & Older	
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	No copay or coinsurance <i>(deductible waived)</i>
Adult Preventive Services <i>(including mammograms, Pap smears, & prostate cancer screenings)</i>	No copay or coinsurance <i>(deductible waived)</i>
Hearing Exams	20%

Covered Services	PPO: Per Insured Person Copay/ Coinsurance
Physical Therapy, Physical Medicine & Occupational Therapy, Speech Therapy <i>(limited to \$5,000/benefit year combined)</i>	20%
Chiropractic, Acupuncture, Osteopathic Manipulation	
➤ Services for the treatment of disease, illness or injury <i>(limited to 20 visits/benefit year combined)¹</i>	20%
Temporomandibular Joint Disorders	
➤ Splint therapy & surgical treatment	20%
Pregnancy & Maternity Care <i>(services cover insured dependent spouse/domestic partner & dependent daughters)</i>	
➤ Physician office visits	20% Coinsurance applies to first visit only; Subsequent visits – No coinsurance
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	20%
Normal delivery, cesarean section, complications of pregnancy, or abortion <i>(newborn routine nursery care covered when natural mother is insured person)</i>	
➤ Inpatient physician services	20%
➤ Hospital & ancillary services	20%
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])</i>	
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric CME <i>(member's transportation to & from CME limited to \$130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to \$130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & \$100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & \$100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to \$25/day/person for 4 days/trip)</i>	No copay/coinsurance <i>(deductible waived)</i>
Diabetes Education Programs <i>(requires physician supervision)</i>	
➤ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	20%

¹ Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Insured Person Copay/Coinsurance
Prosthetic Devices	
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for insured persons with diabetes	20%
Durable Medical Equipment (limited to \$5,000/benefit year combined)	
➤ Rental or purchase of DME including dialysis equipment & supplies	20%
➤ Hearing Aids (limited to one aid per ear every 4 years)	20%
Related Outpatient Medical Services & Supplies	
➤ Ground ambulance transportation, services & disposable supplies	20%
➤ Air ambulance transportation, services & disposable supplies (limited to \$25,000/benefit year)	20%
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%
➤ Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	20%
Emergency Care	
➤ Emergency room services & supplies	\$100 copay plus 20% (deductible waived) (copay waived if admitted)
➤ Inpatient hospital services & supplies	20%
➤ Physician services	20%
➤ Urgent Care Center	\$50 copay plus 20% (deductible waived)
Mental or Nervous Disorders and Substance Abuse	
Inpatient Care	
➤ Facility-based care (subject to utilization review; waived for emergency admission)	20%
➤ Inpatient physician visits	20%
Outpatient Care	
➤ Facility-based care (subject to utilization review; waived for emergency admission)	20%
➤ Outpatient physician visits (pre-service review required after the 12th visit)	20%
➤ Neuropsychological Testing	20%

Covered Services	PPO: Per Insured Person Copay/Coinsurance
Organ & Tissue Transplants (preauthorization required);	
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%
➤ Physician office visits (including specialists and consultants)	20%
➤ Transplant travel expense for an authorized, specified transplant at a CME (recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days)	No copay/coinsurance (deductible waived)
Medical Evacuation Benefit for Dependents of Students (expenses for transporting insured person back to home country for medical care & treatment limited to \$10,000; see Benefit Booklet for specific details)	
	No copay or coinsurance (deductible waived)
Exclusions applicable to Medical Evacuation— No payment will be made for expenses incurred for or in connection with any of the items below:	
➤ Mild conditions. Services for medical evacuation when insured person has mild lesions, simple injuries such as sprains, simple fractures, or mild illness, which can be treated in the United States, or, if insured person is a United States student outside the United States, in the country where studying, which does not prevent insured person from continuing to participate in the Exchange Visitor Program for which insured person came to the United States for.	
➤ Not covered. Services received before insured person's effective date, services not specifically stated, such as care or treatment of an illness or injury.	
➤ Not needed. Services for medical evacuation when physician does not certify, in writing, that insured person needs further medical care or treatment for an illness or accident that commenced or occurred, respectively, in the United States or, if insured person is a United States student outside the United States, in the country where studying.	
➤ Traveling Companions. The cost of airfare for a family member or traveling companion accompanying the insured person.	
Repatriation Benefit for dependents of Students (in the event of insured person's death, expenses for preparing & transporting the insured person's bodily remains back to home country limited to \$7,500; see Benefit Booklet for specific details.)	
	No copay or coinsurance (deductible waived)
Exclusions applicable to Repatriation Benefit— No payment will be made for expenses incurred for or in connection with any of the items below:	
➤ Not covered. Services received before insured person's effective date	
➤ Death Outside the United States. Services furnished to prepare and transport the insured person's remains to country of legal residence if death occurred outside the United States, except for U.S. dependents traveling abroad with student.	

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Benefit Booklet, which explains the full range of covered services of the plan, in detail.

PPO Student Health Plan—Prudent Buyer Plan Exclusions

Acupuncture. Acupuncture treatment, except as specified as covered in the Benefit Booklet.
Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Air Conditioners: Air purifiers, air conditioners or humidifiers.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Benefit Booklet.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Benefit Booklet.

Cosmetic Surgery: Except reconstructive surgery as a result of accidental Injury or Sickness that occurs while eligible for SHIP benefits.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Benefit Booklet.

Dental Services or Supplies: Braces, orthodontic appliances, and orthodontic services.
Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums. Cosmetic dental surgery or other services for beautification. Dental coverage is offered through Delta Dental Insurance.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Benefit Booklet.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Benefit Booklet. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Excess Amounts. Any amounts in excess of covered expense or the benefit year maximum.

Excess Coverage – Anthem Blue Cross Life and Health Insurance Company will reduce the amount payable under this plan if expenses are covered under any other plan. We will determine the amount of benefits provided by other plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from other plans includes any amount to which the insured person is entitled, whether or not a claim is made for the benefits. The coverage under this policy is secondary coverage to all other policies.

Exercise Equipment: Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a physician.

Experimental, or Unnecessary Medical Treatment/Testing: Includes medical services that are not medically necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with experimental or investigational treatment.
Crime, 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.

Eye Surgery for Refractive Defects. 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.

Government Treatment. Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay for them or they are given to the insured person for free.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the Benefit Booklet.

Infertility Treatment: Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, sterilization reversal, in vitro fertilization and gamete intrafallopian transfer. Infertility is:

1. the presence of a condition recognized by a Physician as the cause of infertility or
2. the inability to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Intercollegiate Sports Injuries: Treatment of Injury sustained while participating in, practicing or conditioning for, or traveling in conjunction with, any intercollegiate sport, contest or competition, or any University-sponsored (including intramural) program in the martial arts.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders and substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Benefit Booklet.

Nasal Surgery: Except medically-necessary surgical treatment, or due to a medically documented accidental Injury that occurs while eligible for SHIP benefits.

Not Covered. Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Benefit Booklet.

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Obesity/Weight Reduction: Services primarily for weight reduction or treatment of obesity. Treatment of morbid obesity may be a covered benefit, subject to verification of diagnosis and utilization review for medical appropriateness and necessity following Anthem Blue Cross Medical Review criteria.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, eyeglasses or contact lenses, except as specified as covered in the Benefit Booklet. Vision benefits are offered as a rider to the medical plan. Please refer to Vision Summary Plan Document.

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications, except as specified as covered in the Benefit Booklet.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or infusion therapy provider, except as specified as covered in the Benefit Booklet.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids

Nutrition Consultation: Except for services provided at the on-campus Student Health Services and Counseling Centers, and diabetes education program covered as medical office visits. medications and insulin, except as specified as covered in the Benefit Booklet. Any non- Personal Items: Any supplies for comfort, hygiene or beautification.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Benefit Booklet.

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

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Reversal of sterilization.

Routine Exams or Tests: Except as specifically defined as a covered benefit of the plan, any physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment, government authority and travel.
Preventive/Elective Services. Testing, treatment, or services for any condition in the absence of Sickness or Injury except those specifically defined as covered benefits.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Services Performed by a Family Member: All medical and psychological treatment, or services performed by any member of your immediate family.

Sex Sterilization Reversal.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex except as specified as covered in the Benefit Booklet.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Speech Disorders: Services primarily for correction of speech disorders, including, but not limited to stuttering or stammering.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Unstated Treatment, Services and Supplies: UC SHIP will not pay benefits for any treatment, service, or supply that has not been listed herein as a covered service or item, even if it has not been specifically identified as an "excluded" item.

Workers' Compensation Services: Treatment of any Sickness or Injury eligible for compensation under any Workers' Compensation or Occupational Disease Law.

Voluntary Payment. Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

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