### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| UC Family Providers & the Ashe Center: | $0 per Member  
PPO Providers: $300 per Member  
Non-PPO Providers: $500 per Member | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check the 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. | You don’t have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers. |

| **Is there an out-of-pocket limit on my expenses?** | Yes. For UC Family Providers & the Ashe Center: $2,000 Member  
For PPO Providers: $3,000 Member  
For Non-PPO Providers: $6,000 Member | 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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### Important Questions | Answers | Why this Matters:
---|---|---
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. | The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers? | Yes, but you must seek care at the Ashe Center first. See [www.anthem.com/ca](http://www.anthem.com/ca) or call 1-866-940-8306 for a list of UC Family and PPO 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. 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 a written Referral from the Ashe Center on campus 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 under UC SHIP, but only if you obtain a Referral before you 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 9. See your Benefit Booklet for additional information about services that are not covered.

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Anthem Blue Cross  
University of California Student Health Insurance Plan (UC SHIP)  
Custom UCLA  
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 2014 – 2015 Plan Year  
Coverage for: Individual  
Plan Type: PPO

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 **UC Family** and **Anthem PPO Providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.
- A **Referral** is a written authorization given by the Ashe Center to seek care outside of the Ashe Center for medically necessary care.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Tier 1: Your Cost If You Use a UC Family Provider</th>
<th>Tier 2: Your Cost If You Use a PPO Provider</th>
<th>Tier 3: Your Cost If You Use a Non-PPO Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$0 Ashe Center/ $10 UC Family Copayment/ Visit</td>
<td>$25 Copayment/ Visit</td>
<td>40% Coinsurance</td>
<td>Students must start care at the Ashe Center or obtain a <strong>Referral</strong> for services. Deductible waived for PPO Providers.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$0 Ashe Center/ $15 UC Family Copayment/ Visit</td>
<td>$40 Copayment/ Visit</td>
<td>40% Coinsurance</td>
<td>Deductible waived for PPO Providers.</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Other practitioner office visit</td>
<td></td>
<td>Chiropractor $15 Copayment/Visit</td>
<td>Chiropractor $40 Copayment/Visit</td>
<td>Chiropractor 40% Coinsurance</td>
<td>Deductible waived for PPO Providers. Acupuncture coverage is limited to a total of 20 visits.</td>
</tr>
<tr>
<td>Acupuncturist $15 Copayment/Visit</td>
<td></td>
<td>Acupuncturist $15 Copayment/Visit</td>
<td></td>
<td>Acupuncturist 40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td></td>
<td>No Cost Share</td>
<td>No Cost Share</td>
<td>Not Covered</td>
<td>----none------</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>No cost for X-rays at the Ashe Center. This excludes X-ray and lab services performed for a Preventive Exam.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Costs may vary by site of service. You should refer to the Benefit Booklet for details.</td>
<td></td>
</tr>
</tbody>
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### University of California Student Health Insurance Plan (UC SHIP)
#### Custom UCLA
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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic Drugs</td>
<td>$5 Copayment at the Ashe Center/$10 Copayment at other UC Family Pharmacies*</td>
<td>$10 Copayment/Prescription</td>
<td>$10 Copayment/Prescription + any amount over the contracted rate</td>
<td>Covers up to a 30 day supply. Not subject to Deductible. Pharmacies are contracted with Ventegra. Please see <a href="http://www.ventegra.net">www.ventegra.net</a> for a list of Participating Providers.</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs</td>
<td>$25 Copayment at the Ashe Center/$40 Copayment at other UC Family Pharmacies*</td>
<td>$40 Copayment/Prescription</td>
<td>$40 Copayment/Prescription + any amount over the contracted rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand Drugs</td>
<td>$40 Copayment at the Ashe Center/$60 at other UC Family Pharmacies*</td>
<td>$60 Copayment/Prescription</td>
<td>$60 Copayment/Prescription + any amount over the contracted rate</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% Coinsurance</td>
<td>$125 plus 20% Coinsurance</td>
<td>$250 plus 40% Coinsurance</td>
<td>Certain surgeries are subject to utilization review for UC Family, PPO and Non-PPO facilities.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>---------------none---------------</td>
</tr>
</tbody>
</table>

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room services</td>
<td>$125 Copayment/Visit</td>
<td>$125 Copayment/Visit</td>
<td>$125 Copayment/Visit</td>
<td>Copayment waived if admitted; deductible waived for PPO and Non-PPO Providers. Member may be responsible for any costs above the allowed amount for a Non-PPO provider.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>No cost for air ambulance services when medically necessary.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$25 Copayment/Visit</td>
<td>$25 Copayment/Visit</td>
<td>40% Coinsurance</td>
<td>Deductible waived for PPO Providers. You should refer to the Benefit Booklet for coverage details.</td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>10% Coinsurance</td>
<td>$250 plus 20% Coinsurance</td>
<td>$500 plus 40% Coinsurance</td>
<td>Subject to utilization review for inpatient and certain outpatient services at all facilities; waived for emergency admissions.</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>---none---</td>
</tr>
</tbody>
</table>

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<th>Services You May Need</th>
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<th>Tier 3: Your Cost If You Use a Non-PPO Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>N/A*</td>
<td>N/A*</td>
<td>N/A*</td>
<td>*Benefits are provided by UCLA Neuropsychiatric Behavioral Health Sciences (NBHS) with a referral from the Counseling and Psychiatric Services (CAPS) or prior referral from NBHS if you are out of area. Contact UCLA NBHS or the Ashe Center for information. Contact CAPS at (310) 825-0768 or UCLA NBHS at (800) 825-9989.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>N/A*</td>
<td>N/A*</td>
<td>N/A*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder outpatient services</td>
<td>N/A*</td>
<td>N/A*</td>
<td>N/A*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder inpatient services</td>
<td>N/A*</td>
<td>N/A*</td>
<td>N/A*</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$10 Copayment for Initial Visit; then covered 100%</td>
<td>$25 Copayment for Initial Visit; then covered 100%</td>
<td>40% Coinsurance</td>
<td>Deductible waived for PPO Providers. Copayment applies to first visit only, thereafter no cost.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>10% Coinsurance</td>
<td>$250 plus 20% Coinsurance</td>
<td>$500 plus 40% Coinsurance</td>
<td>Subject to utilization review for inpatient and certain outpatient services at all facilities; waived for Emergency admissions.</td>
</tr>
</tbody>
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<th>Tier 3: Your Cost If You Use a Non-PPO Provider</th>
<th>Limitations &amp; Exceptions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No Cost Share</td>
<td>No Cost Share</td>
<td>40% Coinsurance</td>
<td>Services will not be covered if utilization review is not obtained; limited to one visit by a home health aide equals four hours or less. Not covered while member receives hospice care.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 Copayment/Visit</td>
<td>$40 Copayment/Visit</td>
<td>40% Coinsurance</td>
<td>Deductible waived for PPO Providers. Costs may vary by site of service. You should refer to the Benefit Booklet for details.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 Copayment/Visit</td>
<td>$40 Copayment/Visit</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Services will not be covered if utilization review not obtained.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>--------none------------</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>--------none------------</td>
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Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your Benefit Booklet for other excluded services.)</th>
<th>Other Covered Services (This isn’t a complete list. Check your Benefit Booklet for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
<td>• Medical evacuation and repatriation</td>
</tr>
<tr>
<td>• Dental care</td>
<td>• 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.)</td>
</tr>
<tr>
<td>• Erectile dysfunction medications</td>
<td>• Most coverage provided outside the United States. See <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a></td>
</tr>
<tr>
<td>• Exams or tests required for participation in an academic, recreational, or employment activity</td>
<td>• Psycho-educational testing (limited to $3,000 per lifetime)</td>
</tr>
<tr>
<td>• Experimental or unnecessary medical treatment</td>
<td>• Bariatric surgery (For morbid obesity, consult your Benefit Booklet.)</td>
</tr>
<tr>
<td>• Infertility diagnosis &amp; treatment</td>
<td>• Intercollegiate sports injuries</td>
</tr>
<tr>
<td>• Intercollegiate sports injuries</td>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
<td>• Routine eye care</td>
</tr>
<tr>
<td>• Routine foot care unless you have been diagnosed with diabetes. Consult your Benefit Booklet</td>
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</tr>
<tr>
<td>• Services performed without a Student Health referral referral, except in an emergency</td>
<td>• Weight Loss programs</td>
</tr>
<tr>
<td>• Intercollegiate sports injuries</td>
<td>• Work-related conditions covered by Workers Compensation</td>
</tr>
<tr>
<td>• Long-term care</td>
<td>• Weight Loss programs</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
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<td>• Routine eye care</td>
<td>• Weight Loss programs</td>
</tr>
<tr>
<td>• Routine foot care unless you have been diagnosed with diabetes. Consult your Benefit Booklet</td>
<td>• Work-related conditions covered by Workers Compensation</td>
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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
ATTN: Appeals or Grievance
P.O. Box 4310
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.

如果您是非会员并且需要中文协助，请联络您的销售代表或小组管理员。如果您已参保，则请使用您ID卡上的号码联络客户服务人员。

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’th两边 邦从 dosa’i, shikaa adoolwol jinizingo t’aa diné k’éjígo, t’aa shoosi ba na’alñihi ya sidáhí bích’i naabúúlkiid. Eí doo bágha daqo ní ba’ñija’go ho’alagú bích’i hodiilní. Hai’dáa iní’tago eíya, t’aa shoosi diné ya atah halne’ígíí ni bée’sh bee hane’i wólta’ bi’ki si’nillííí bi’ké’go bích’i hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mại của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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

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 http://www.anthem.com/ca or call 1-866-940-8306 to request a copy.
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.

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### Having a baby (normal delivery)
- **Amount owed to providers:** $7,540
- **Plan pays:** $6,960
- **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
- Copayments: $60
- Coinsurance: $320
- Limits or exclusions: $0

**Total:** $580

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### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays:** $4,690
- **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
- Copayments: $330
- Coinsurance: $180
- Limits or exclusions: $0

**Total:** $710

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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.

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*The University of California Student Health Insurance Plan is a self-funded Plan that voluntarily complies with major requirements of the Affordable Care Act.*
Anthem Blue Cross
University of California Student Health Insurance Plan (UC SHIP)
Custom UCLA Coverage Period: 2014 – 2015 Plan Year
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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.

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