

Your summary of benefits



Anthem Blue Cross Life and Health Insurance Company

UC IRVINE UNDERGRADUATE STUDENT HEALTH INSURANCE PLAN (USHIP)

This summary of benefits is a brief outline of your health insurance coverage. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC) that is available on the UCI Student Health Center website: www.shc.uci.edu. If there is a difference between the EOC and this summary, the EOC will prevail.

STUDENT HEALTH CENTER REFERRAL REQUIREMENT

The Student Health Center (SHC) is the primary care provider for students covered under the plan. The covered student must use services of the Student Health Center first where treatment will be administered. Referral will be issued to an in-network specialist or facility in the community. The community specialist or facility must include the referral issued by the SHC when their claim is submitted. A referral will be valid for the entire academic year but will expire and need to be renewed if the covered student has not made an appointment with the community specialist or facility within 90 days of the date of referral. The covered student will not need a subsequent referral for associated tests ordered by and follow-up appointments scheduled with the community specialist. However, if the covered student is referred by a specialist to another specialist, then a new referral is required.

Covered charges incurred for medical treatment rendered outside of the Student Health Center for which a prior referral was not obtained will not be paid, except under the following conditions:

1. Medical Emergency and Urgent Care. (The student must return to the SHC for necessary follow-up care);
2. When the SHC is closed;
3. When service is rendered at another facility during break or vacation periods;
4. Medical care received when the student is more than 50 miles from campus;
5. Medical care received when a student is no longer able to use the SHC due to a change in student status;
6. Pharmacy services;
7. Dental and vision services rendered by a dentist or optometrist under those respective plan benefits (refer to the Delta Dental and Anthem Blue View VisionSM plan documents on the SHC website: www.shc.uci.edu)
8. Obstetrical or gynecological care; or
9. Treatment of Mental Conditions.

Dependents are not eligible to use the SHC and are exempt from the above referral requirements.

UC IRVINE'S ADMISSION HEALTH REQUIREMENTS

For information regarding UCI's Admission Health Requirements that must be completed either prior to the start of the Fall quarter (i.e., TB screening and/or testing) or prior to the start of the Winter quarter (i.e., immunizations), please visit the *Admission Health Requirements* page on SHC's website: www.shc.uci.edu.

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Covered Medical Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible per policy year <i>See notes section to understand how your deductible works. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.</i>	N/A	\$200 student/\$600 family	\$300 student/\$900 family
Out-of-Pocket Limit per policy year <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. Non-Network Providers out-of-pocket maximums are combined. Satisfying one helps satisfy the other.</i>	N/A	\$1,600 student/\$12,700 family	\$6,000 student/\$18,000 family
Doctor Home and Office Services			
Preventive care/screening/immunization <i>SHC and In-network preventive care are not subject to deductible.</i>	No charge	No charge	40% coinsurance
Primary care visit to treat an injury or illness	\$15 copay per visit <i>(Deductible waived)</i>	\$15 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Specialist care visit	\$30 copay per visit <i>(Deductible waived)</i>	\$30 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Prenatal and Post-natal Care <i>Copay applies to first visit only for In network providers.</i>	N/A	\$15 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Other practitioner visits:			
Retail health clinic	N/A	\$15 copay per visit <i>(Deductible waived)</i>	40% coinsurance
On line Visit	N/A	\$15 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Chiropractor services	\$10 copay per visit <i>(Deductible waived)</i>	\$30 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Acupuncture	N/A	\$30 copay per visit <i>(Deductible waived)</i>	40% coinsurance

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Other services in an office:			
Allergy testing	N/A	10% coinsurance	40% coinsurance
Chemo/radiation therapy	N/A	10% coinsurance	40% coinsurance
Hemodialysis	N/A	10% coinsurance	40% coinsurance
Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	N/A	10% coinsurance	40% coinsurance
Diagnostic Services			
Lab:			
Office	10% coinsurance <i>(Deductible waived)</i>	10% coinsurance	40% coinsurance
Freestanding Lab	N/A	10% coinsurance	40% coinsurance
Outpatient Hospital	N/A	10% coinsurance	40% coinsurance
X-ray:			
Office	10% coinsurance <i>(Deductible waived)</i>	10% coinsurance	40% coinsurance
Freestanding Radiology Center	N/A	10% coinsurance	40% coinsurance
Outpatient Hospital	N/A	10% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):			
Office	N/A	10% coinsurance	40% coinsurance
Freestanding Radiology Center	N/A	10% coinsurance	40% coinsurance
Outpatient Hospital	N/A	10% coinsurance	40% coinsurance
Emergency and Urgent Care			
Emergency room facility services <i>Copay waived if admitted to Hospital.</i>	N/A	\$100 copay per visit <i>(Deductible waived)</i>	\$100 copay per visit <i>(Deductible waived. Paid at 100% of reasonable and customary)</i>

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Covered Medical Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency room doctor and other services	N/A	No charge	No charge
Ambulance (air and ground)	N/A	10% coinsurance	Covered as In-Network
Urgent Care (office setting)	\$15 copay per visit <i>(Deductible waived)</i>	\$25 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse			
Doctor office visit	\$15 copay per visit <i>(Deductible waived)</i>	\$15 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Facility visit: Facility fees	N/A	10% coinsurance	40% coinsurance
Outpatient Surgery			
Facility fees:			
Hospital	N/A	10% coinsurance	40% coinsurance
Freestanding Surgical Center	N/A	10% coinsurance	40% coinsurance
Doctor and other services	N/A	10% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)			
Facility fees (for example, room & board) <i>Co-pay \$500 for Out-of-Network Provider. Apply to non-emergency admission.</i>	N/A	10% coinsurance	40% coinsurance
Doctor and other services	N/A	10% coinsurance	40% coinsurance
Recovery & Rehabilitation			
Home health care <i>Pre-Certification required</i>	N/A	No charge	40% coinsurance

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Covered Medical Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):			
Office	N/A	\$30 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Outpatient hospital	N/A	\$30 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Habilitation services	N/A	\$30 copay per visit <i>(Deductible waived)</i>	40% coinsurance
Cardiac rehabilitation			
Office	N/A	10% coinsurance	40% coinsurance
Outpatient hospital	N/A	10% coinsurance	40% coinsurance
Skilled nursing care (in a facility) <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period.</i>	N/A	10% coinsurance	40% coinsurance
Hospice	N/A	10% coinsurance	40% coinsurance
Durable Medical Equipment	No charge <i>(Deductible waived)</i>	10% coinsurance	10% coinsurance
Prosthetics Devices	No charge <i>(Deductible waived)</i>	10% coinsurance	10% coinsurance
Podiatry	N/A	10% coinsurance	40% coinsurance
Psycho-educational Testing	N/A	10% coinsurance	10% coinsurance
Neuropsychological Testing	N/A	10% coinsurance	40% coinsurance
Medical Evacuation <i>Deductible does not apply. Charges do not apply toward Out-of-Pocket Maximum. Expenses for transporting insured person back to home country for medical care & treatment limited to \$50,000; see certificate for specific details.</i>	N/A	No charge	No charge

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Covered Medical Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Repatriation of Remains <i>Deductible does not apply. Charges do not apply toward Out-of-Pocket Maximum. In the event of insured person's death, expenses for preparing & transporting the insured person's bodily remains back to home country limited to \$25,000; see Certificate for specific details.</i>	N/A	No charge	No charge
Care outside of U.S. Blue Cross Blue Shield Global Core (including non-emergency foreign claims).	N/A	See applicable benefit	See applicable benefit
Children's Vision Essential Health Benefits <i>Limited to covered persons under the age 19</i>			
Vision exam <i>Includes one exam/fitting per year</i>	N/A	No charge	See separate allowances
Frames <i>Includes one per year</i>	N/A	No charge	See separate allowances
Lenses <i>Includes one per year</i>	N/A	No charge	See separate allowances
Elective contact lenses <i>Includes one per year</i>	N/A	No charge	See separate allowances

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Covered Dental Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Limited to covered persons under the age 19</i>	No charge	No charge	No charge
Basic services	10% coinsurance	10% coinsurance	10% coinsurance
Major services	10% coinsurance	10% coinsurance	10% coinsurance
Orthodontic Care	10% coinsurance	10% coinsurance	10% coinsurance
Deductible	\$60/insured person/ \$180 Family		
Annual Out of Pocket maximum	\$1,000 student/\$2,000 family		No maximum for Non-Network Provider

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Covered Prescription Drug Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	\$0	\$0	\$0
Pharmacy Out of Pocket Maximum <i>(Prescription drugs apply to the Out-of-Pocket limit)</i>	\$0	\$0	\$0
Prescription Drug Coverage			
Preventive Pharmacy			
Preventive Immunization	\$0 copay (retail only)	\$0 copay (retail only)	40% coinsurance up to \$250 per prescription (retail only)
Female oral contraceptive <i>Generic and Single Source brand</i>	\$0 copay (retail only)	\$0 copay (retail only)	40% coinsurance up to \$250 per prescription (retail only)
Tier1 - Typically Generic <i>Member pays the retail pharmacy copay plus 40% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i>	\$5 copay (retail only)	\$5 copay (retail only) and \$10 copay (home delivery only)	40% coinsurance up to \$250 per prescription (retail only)
Tier2 - Typically Preferred / Brand <i>Member pays the retail pharmacy copay plus 40% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i>	\$35 copay per prescription (retail only)	\$35 copay per prescription (retail only) and \$70 copay per prescription (home delivery only)	40% coinsurance up to \$250 per prescription (retail only)
Tier3 - Typically Non-Preferred / Specialty Drugs <i>Certain drugs require preauthorization approval to obtain coverage. Member pays the retail pharmacy copay plus 40% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i>	\$50 copay per prescription (retail only)	\$50 copay per prescription (retail only) and \$100 copay per prescription (home delivery only)	40% coinsurance up to \$250 per prescription (retail only)

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Covered Prescription Drug Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier4 - Typically Specialty Drugs <i>Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Member pays the retail pharmacy copay plus 40% for out of network. Limited to a 30 day supply.</i>	Not covered	Covered 100% after Tier 1: \$5 Tier 2: \$35 Tier 3: \$50	Not covered

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- In network and out of network deductible and out of pocket maximum cross apply.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- *Participating providers* have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. *Participating providers* agree to accept the *maximum allowed amount* as payment for covered services.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO. Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.

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- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to five consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Preferred Generic Program: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Prescription drugs apply to the Out-of-Pocket limit.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

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Contact Information – Anthem Blue Cross

Insurance Company	Anthem Blue Cross
Customer Service & Benefit Questions <i>For questions regarding eligibility, benefits, locate a provider or to check claims status</i>	844-437-0493 www.anthem.com/ca
Claims Submission <i>For submitting claims by mail, complete a claim form or make a copy of your insurance ID card and the bill(s) and send to:</i>	Anthem Blue Cross P.O. Box 60007 Los Angeles CA 90067-0007
Pre-Certification for Hospitalization <i>Pre-Certification is required for all inpatient hospitalization. Prior to scheduled hospitalization, or after an emergency admission</i>	800-274-7767
Prescription Drugs <i>To locate a network pharmacy other than SHC Pharmacy and to manage your medications (including refills and home delivery)</i>	800-700-2541
Travel Assistance Services <i>When you are traveling away from home and you need assistance with things such as transfer of medical records, legal referrals, transfer of funds, and information on travel conditions</i>	Blue Card World Wide 800-810-2583(BLUE)
After-hours Nurse Line <i>If quick, sound medical advice is necessary when the UCI Student Health Center is closed, simply call Anthem's 24/7 Nurseline</i>	800-977-0027

Contact Information – UCI Student Health Center

Appointments – Medical Clinics/Psychiatry Service	949-824-5304
Appointments – Dental Clinic	949-824-5307
General Information	949-824-5301
Pharmacy	949-824-5923
Insurance Services	949-824-2388 Fax: 949-824-5062 shc-insurance@uci.edu
Patient Billing Inquiries	949-824-7084 Fax: 949-824-5062 shc-billing@uci.edu
Medical Records	949-824-5302 Fax: 949-824-3033 shc-medical-records@uci.edu

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