***UNIVERSITY OF CALIFORNIA***

***STUDENT HEALTH INSURANCE PLAN (UC SHIP)***

*2017 – 2018 Plan Year*

# *Blue View Vision*
# *Plan Booklet*

SPD275958-11 0717

Dear Plan Member:

This Plan Booklet provides a detailed explanation of your benefits, limitations and other *plan* provisions which apply to you.

Covered students and dependents ("members") are referred to in this Booklet as "you" and "your". The *plan administrator* is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found in the DEFINITIONS section of this Booklet.

Please read this *Plan Booklet* carefully so that you understand all the benefits your *plan* offers. Keep this *Plan Booklet* handy in case you have any questions about your coverage.

**Important:** This is not an insured benefit *plan*. The benefits described in this *Plan Booklet* or any amendments hereto are funded by the University. Anthem Blue Cross Life and Health Insurance Company performs all administrative services in connection with the processing of claims under the *plan* and has full and final discretion and authority to determine whether and to what extent members are entitled to benefits under the *plan*. Anthem Blue Cross Life and Health Insurance Company does not assume any financial risk or obligation with respect to the funding of benefits.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association.

**UC SHIP Member Services Number: 1-866-940-8306**

**UC SHIP website: www.ucop.edu/ucship**

## COMPLAINT NOTICE

**All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number provided on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Member Services Department). If you wish, the *claims administrator* will provide a Complaint Form which you may use to explain the matter.**

**All grievances received under the *plan* will be acknowledged in writing, together with a description of how the *claims administrator* proposes to resolve the grievance.**

**Grievances relating to eligibility for coverage under the *plan* should be submitted to your campus student health and counseling services, in writing, within 60 days of the notification that you are not eligible for coverage. You should include all information and documentation on which your grievance is based. The student health and counseling services will notify you in writing of its conclusion regarding your eligibility. If the student health and counseling services confirms the determination that you are ineligible, you may request, in writing, that the UC Student Health Insurance Plan (UC SHIP) office review this decision. Your request for review should be sent within 60 days after receipt of the notice from the student health and counseling services confirming your ineligibility and should include all information and documentation relevant to your grievance. Your request for review should be submitted to: University of California Student Health Insurance Plan, Risk Services, 1111 Franklin Street, 10th Floor, Oakland, CA 94607. The decision of the UC SHIP Director will be final.**

**UC SHIP Member Services Number: 1-866-940-8306**

**UC SHIP website: www.ucop.edu/ucship**

Claims Administered by:

*ANTHEM BLUE CROSS*

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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# HOW COVERAGE BEGINS AND ENDS

## HOW COVERAGE BEGINS

### ELIGIBLE STATUS

### Insured Students

1. The following classes of students are automatically enrolled as insured students:

    a. All registered students, including domestic and international students of the following University of California campuses:

        i. Davis
        ii. Hastings College of the Law
        iii. Irvine
        iv. Los Angeles
        v. Merced
        vi. Riverside
        vii. San Diego
        viii. San Francisco
        ix. Santa Cruz

    b. All graduate students of the University of California campuses listed in 1.a. who are registered in-absentia.

    c. Individuals on the UC San Francisco campus enrolled in the "Scholars and Researchers Health Plan" which encompasses persons who are non-registered students, but are scholars and/or researchers engaged in a program or academic pursuit approved by the campus. Each enrollee must present evidence of official approval from a campus representative of the program.

    **Note:** A student may waive enrollment in UC SHIP during the waiver period specified by his or her home campus by providing proof of other medical coverage that meets medical benefit criteria specified by the University. A waiver is effective for one academic year and must be completed again during the waiver period at the start of each fall quarter or semester of the academic year. Waiver requests for each academic term within a year (Winter or Spring quarter or semester) are also available. Information about waiving enrollment in UC SHIP may be obtained from the student health insurance office on the student's campus.

2. The following classes of individuals may enroll voluntarily as insured students:

a. All non-registered "Filing Fee" status students of the University of California campuses at Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco and Santa Cruz, who are completing work under the auspices of the University of California, as determined by the campus but are not attending classes. Students on Filing Fee status may purchase *plan* coverage for a maximum of one semester or one quarter. These students may enroll by contacting Wells Fargo Insurance Services at 800-853-5899.

b. All non-registered graduate and undergraduate students at Davis, Merced, and Santa Cruz; Los Angeles graduate students and Riverside undergraduates who are on a Planned Educational Leave (PELP); graduate students at Irvine, Los Angeles, Riverside, San Diego, San Francisco; and Santa Cruz graduate and undergraduate students who are on an approved Leave of Absence (LOA). These students may purchase *plan* coverage for a maximum of one semester or two quarters and may enroll by contacting Wells Fargo Insurance Services at 800-853-5899.

c. All former students of the University of California campuses who completed their degree (graduated) during the term immediately preceding the term for which they want to purchase coverage. These individuals may purchase UC SHIP for a maximum of one semester or one quarter. These individuals may enroll by contacting Wells Fargo Insurance Services at 800-853-5899. The student must be covered by the *plan* in the term immediately preceding the term for which the student wants to purchase coverage.

**NOTE:** Non-registered students described in number 2 above may purchase UC SHIP only if they also meet the following criteria:

a. They were enrolled in UC SHIP during the immediately preceding academic term; or

b. They show proof of involuntary loss of their other coverage within the prior 30 days.

**Eligible Dependents**

1. The following classes of dependents of insured students may enroll voluntarily in the *plan*:

   a. Spouse: Legal *spouse* of the *insured student*.

b. Domestic Partner: The individual designated as an *insured student's domestic partner* under one of the following methods: (i) registration of the partnership with the State of California; (ii) establishment of a same-sex legal union, other than marriage, formed in another jurisdiction that is substantially equivalent to a State of California-registered domestic partnership; or (iii) filing of a Declaration of Domestic Partnership form with the University. An insured student's opposite-sex *domestic partner* will be eligible for coverage only if one or both partners are age 62 or over and eligible for Social Security benefits based on age.

c. *Child*: The *insured student's child(ren)* as follows:

- Biological *child* under the age of 26
- Stepchild: A stepchild under the age of 26 is a *dependent* as of the date the *insured student* marries the *child's* parent.
- Adopted *child* under the age of 26, including a *child* placed with the *insured student* or the *insured student's spouse* or *domestic partner,* for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- *Child* of the *insured student's domestic partner*: A *child* of the *insured student's domestic partner* under the age of 26 is a *dependent* as of the *effective date* of the domestic partnership.
- Foster Child: A foster *child* under the age of 18 is a *dependent* from the moment of placement with the *insured student* as certified by the agency making the placement. In certain circumstances, the foster *child* age limit may be extended in accordance with the provision for a non-minor dependent, as defined in the California Welfare and Institutions Code Section 11400 (v).
- A *child* for whom the insured student is legally required to provide health insurance in accordance with an administrative or court order, provided that the *child* otherwise meets UC SHIP eligibility requirements.

- Dependent Adult Child: A *child* who is 26 years of age or older and: (i) was covered under the *prior plan*, or has six or more months of creditable coverage, (ii) is chiefly dependent on the *student, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* is incapable of self-sustaining employment due to a physical or mental condition. The University may request proof of these conditions in order to continue coverage. The University must receive the certification, at no expense to the University, within 60 days of the date the *student* receives the request. The University may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year after the initial certification. This exception will last until the *child* is no longer chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a *dependent* for federal income tax purposes.

**NOTE: If both student parents or *domestic partners* are covered as insured students, their children may be covered as the dependents of either, but not of both.**

2. Students are required to provide proof of *dependent* status when enrolling their dependents in the *plan*. The following documents will be accepted:

   a. For *spouse*, a marriage certificate

   b. For a *domestic partner*, a Certificate of Registered Domestic Partnership issued by the State of California, or of same-sex legal union other than marriage formed in another jurisdiction, or a completed Declaration of Domestic Partnership form issued by the University

   c. For a biological *child*, a birth certificate showing the student is the parent of the *child*

   d. For a stepchild, a birth certificate, and a marriage certificate showing that one of the parents listed on the birth certificate is married to the student

   *e.* For a biological *child* of a *domestic partner*, a birth certificate showing the *domestic partner* is the parent of the *child*

f. For adopted or foster *child*, documentation from the placement agency showing that the student or the *domestic partner* has the legal right to control the *child's* health care

g. For a *child* covered under a court order, a copy of the document from the court.

To obtain coverage for children, the *plan* may require you to give the *claims administrator* a copy of any legal documents awarding guardianship of such child(ren) to you. This must be provided or translated into English.

**PERIODS OF COVERAGE**

Dates of coverage vary by the campus and program in which the student is enrolled. Please contact the student health and counseling services for information on coverage periods.

**ENROLLMENT**

We do not require written applications from registered students. The University of California will maintain records of all students registered in each academic semester/quarter and, except for those students who provide proof that they have other medical coverage that meets criteria established by the University, all registered students will be enrolled for coverage under this *plan* in each academic semester/quarter for which they are registered.

Students who involuntarily lose their other health coverage during the *coverage period* must notify the student health and counseling services with an official written letter of termination from the previous health insurance carrier. Students will be enrolled in the *plan* as of the date of their involuntarily loss of other coverage if they notify the student health and counseling services within 31 days of the loss of their coverage. If the student does not notify the student health and counseling services within the 31 days, coverage will be effective on the date the student pays the full premium. The premium is not pro-rated for enrollment occurring after the start of a *coverage period*.

Non-registered students who enroll on a voluntary basis, and dependents of students must submit an enrollment application for each term of coverage. Call Wells Fargo at **800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST for enrollment information**. Enrollment applications must be received within the enrollment period dates for the term of coverage, which vary by *coverage period*. Enrollment will not be continued to the next *coverage period* unless a new application is received.

Dependents of students may be enrolled, outside of an enrollment period for a particular *coverage period*, within 31 calendar days of the following events:

1. For *spouse*, the date of issuance of the marriage certificate.
2. For a *domestic partner*, the date of the Declaration of Domestic Partnership issued by the State of California, or same-sex legal union other than marriage formed in another jurisdiction, or the date the completed Declaration of Domestic Partnership form issued by the University is received by the student health and counseling services.
3. For biological *child*, the date of birth.
4. For adopted or foster *child*, the date of placement with the student or *domestic partner*.
5. For any *dependent*, the date of loss of other coverage. An official letter of termination from the insurance carrier must be provided at the time of enrollment in UC SHIP.

**Non-registered students, and dependents enroll by contacting Wells Fargo Insurance Services at 800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST.**

## HOW COVERAGE ENDS

**For students, coverage ends as provided below:**

1. If the *plan* terminates, the student's coverage ends at the same time. This *plan* may be canceled or changed at any time without notice. If the *plan* terminates or changes, an *insured student* will remain covered for claims incurred but not filed or paid prior to *plan* termination or change.

2. If the *plan* no longer provides coverage for the class of students to which an *insured student* belongs, the student's coverage ends on the *effective date* of that change.

3. If the student graduates from the University, the student's coverage continues through the last day of the *coverage period* during which the student graduates from the University.

4. If the student withdraws or is dismissed from the University, whether or not coverage will be continued after the date of the withdrawal or dismissal will be determined by campus policy. Contact the student health and counseling services for more information.

5. Enrollment in the *plan* may be terminated for the reasons listed below. The student shall be notified in writing of the termination. Termination shall be effective no less than 30 days following the date of the written notice.

    a. In regard to eligibility for UC SHIP, you knowingly provide material information that is false, or misrepresents information on any document or fail to notify the *plan administrator* of changes in your or your dependents' status.

    b. You knowingly permit the use of your plan identification card by someone other than yourself or your dependents to obtain services; or

    c. You knowingly obtain or attempt to obtain services under the *plan* by means of false, materially misleading, or fraudulent information, acts or omissions.

**Important:** If a marriage or domestic partnership terminates, or if a covered *child* loses dependent child status, the student must give or send Wells Fargo Insurance Services written notice of the termination and loss of eligibility status. Coverage for a former *spouse* or *domestic partner*, or dependent *child*, if any, ends according to the "Eligible Status" provisions. If we suffer a loss because the student fails to notify Wells Fargo Insurance Services of the termination of their marriage or domestic partnership, or of the loss of a *child's* dependent status, we may seek recovery of premiums from the student for any period of

ineligible coverage. Failure to provide written notice to Wells Fargo Insurance Services will not delay or prevent termination of coverage for the *spouse, domestic partner* or *child*. If the student notifies Wells Fargo Insurance Services in writing to cancel coverage for a former *spouse, domestic partner* or *child*, if any, immediately upon termination of the student's marriage, domestic partnership or the *child's* loss of dependent child status, such notice will be considered in compliance with the requirements of this provision.

Contact Wells Fargo Insurance Services at 800-853-5899, Monday through Friday, 8:30 a.m. to 5:00 p.m. PST.

**The Director of UC SHIP is responsible for the final decision on termination of enrollment in the *plan*.**

**For dependents, coverage ends when the student's coverage ends or the *dependent* no longer meets the *dependent* eligibility requirements, whichever occurs first.**

**Enrollment in the *plan* may not be terminated on the basis of sex, race, color, religion, sexual orientation, ancestry, national origin, physical disability or disease status.**

## TYPES OF PROVIDERS

**PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS VISION CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE DEFINITIONS SECTION OF THIS *PLAN BOOKLET*.**

**Network Vision Care Providers.** Anthem Blue Cross Life and Health has contracted with various *vision care providers*, including vision clinics on some campuses, to provide a network of "Network Vision Care Providers." These providers are called "network" because they have agreed to participate in our network provider program, which we call Blue View Vision Insight. They have agreed to provide insured persons with vision care at a negotiated fee. The amount of benefits payable under this *plan* for *out-of-network vision care providers* will be different from, and may be less than, the amount payable for *network vision care providers*.

To find a participating Blue View Vision Insight vision care provider, you may call the Member Services number listed on your ID card or you may also search for a *network vision care provider* using the "Provider Finder" function on our website at **www.ucop.edu/ucship**.

**Out-of-Network Vision Care Providers.** *Out-of-network vision care providers* are providers which have not agreed to participate in our network. They have not agreed to the negotiated rates and other provisions. You will be responsible for any amounts they charge which exceed the Vision Care Benefit Maximum.

## SUMMARY OF BENEFITS

**THE BENEFITS OF THIS *PLAN BOOKLET* ARE PROVIDED ONLY FOR SERVICES WHICH ARE SPECIFIED IN THIS *PLAN BOOKLET* AS COVERED SERVICES. THE FACT THAT YOUR *VISION CARE PROVIDER* PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT A COVERED SERVICE OR A *COVERED VISION EXPENSE*.**

This summary provides a brief outline of your benefits. Please refer to the entire *plan booklet* for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

### VISION CARE BENEFITS

Your vision care benefits cover eye examinations and eyewear only. You can choose to have your eyewear services provided by *network vision care providers* or by *out-of-network vision care providers;* however, your benefits will be affected by this choice.

**CO-PAYMENTS**

**Network Vision Care Provider Co-Payments**

- Comprehensive vision exam ..... **$10**
- Frames..... **No co-payment**
- Lenses – standard plastic single, bifocal, or trifocal vision (one pair) ..... **$25**
- Contact lenses..... **No co-payment**

**Note:** In addition to the Co-Payment shown above, you will be required to pay any amount in excess of the vision care benefit maximums for vision care services. But, when you go to a *network vision care provider*, your cost for vision care services and supplies in excess of the benefit maximum will be at discount prices.

**Out-of-Network Vision Care Provider Co-Payments.** There will be no co-payment required for services and supplies provided by an *out-of-network vision care provider*, but, you will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

**VISION CARE BENEFIT MAXIMUMS**

The *plan* will pay benefits, for the following services and materials, up to the maximum dollar amounts and benefit periods shown below:

**Network Vision Care Provider**

- Comprehensive vision exam ..... **Covered in full**
  after copay
  one exam per *benefit year**
- Frames ..... **$120.00**
  plus **20%** of remaining balance,
  limited to one frame per *benefit year**
- Prescription lenses ..... one pair
  per *benefit year**
  - Single vision lenses ..... **Covered in full**
    after copay
  - Bi-focal lenses ..... **Covered in full**
    after copay
  - Tri-focal lenses ..... **Covered in full**
    after copay
- Non-elective contact lenses ..... **Covered in full**
  once per *benefit year**
- Elective conventional contact lenses** ..... **$120.00**
  then **15%** of remaining balance,
  limited to once per *benefit year**
- Elective disposable contact lenses** ..... **$120.00**
  limited to once per *benefit year**

*Per 12-month period.

** Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a benefit period, the *plan* will not pay benefits for eyeglass lenses during that same benefit period.

**Out-of-Network Vision Care Provider**

- Comprehensive vision exam ..... **$49.00**
  one exam per *benefit year**
- Frames ..... **$50.00**

one frame per *benefit year**

- Prescription lenses.....one pair per *benefit year**
  - Single vision lenses..... **$35.00**
  - Bi-focal lenses..... **$49.00**
  - Tri-focal lenses..... **$74.00**
- Non-elective contact lenses .....**$250.00** once per *benefit year**
- Elective conventional contact lenses**..... **$92.00** once per *benefit year**
- Elective disposable contact lenses**..... **$92.00** once per *benefit year**

*Per 12-month period.

** Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a benefit period, the *plan* will not pay benefits for eyeglass lenses during that same benefit period.

## GENERAL INFORMATION

**Contributions–**The insurance for you and your dependents is *contributory insurance*. You will be informed of the amount of your contribution (premium) when you enroll.

**Anthem Blue Cross Life and Health's Address–**

Anthem Blue Cross Life and Health Insurance Company
Group Services
P.O. Box 70000
Van Nuys, California 91470

## YOUR VISION CARE BENEFITS

### HOW COVERED VISION EXPENSE IS DETERMINED

*Covered vision expense* is based on a maximum charge for each covered service or materials which the *plan* will accept. It is not necessarily the amount a *vision care provider* bills for the service. Expense is incurred on the date you receive the service or materials for which the charge is made.

**Network Vision Care Providers.** The maximum *covered vision expense* for services provided by a *network vision care provider* will be the lesser of the billed charge or the *negotiated rate*. *Network vision care providers* have agreed not to charge you more than the *negotiated rate* for covered services.

If you choose frames or lenses that cost more than the Vision Care Benefit Maximum, you will pay the excess at a discounted price. If you choose vision options that are not covered under this *plan,* you will be charged a discounted price.

**Out-of-Network Vision Care Providers.** The maximum *covered vision expense* for services provided by an *out-of-network vision care provider* will always be the lesser of the billed charge or the Vision Care Benefit Maximum shown in the SUMMARY OF BENEFITS. You will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

**You will always be responsible for an expense incurred which is not covered under this *plan*.**

### VISION CARE CO-PAYMENTS AND BENEFIT MAXIMUMS

After your Co-Payment is subtracted, benefits will be paid up to the amount of *covered vision expense,* not to exceed the applicable Vision Care Benefit Maximum. The Co-Payments and Vision Care Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

### HOW TO USE YOUR VISION CARE BENEFITS

**When You Go to a Network Vision Care Provider.** To identify you as an insured covered for vision care benefits, you will be issued an identification card. You must present this card to *network vision care providers* (which includes your on-campus vision clinic, if any) when you go for your appointment. A *network vision care provider* will only charge your Co-Payment and any charges in excess of the Vision Care Benefit Maximum. When a *network vision care provider* bills for covered services, the *plan* will pay them directly.

**When You Go to an Out-of-Network Vision Care Provider.** If you go to an *out-of-network vision care provider* for services, you will have to pay the full cost of the eye examination and/or for any lenses you purchase. You should make copies of the bills and receipts for your own records. Send the receipt with the original bills attached, along with your ID number, to the address below:

**Anthem Blue Cross Life and Health Insurance Company**
**Blue View Vision**
**P.O. Box 8504**
**Mason, OH 45040-7111**

You must send your receipt from the *vision care provider* with your ID number within 90 days of the date of exam and/or purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

## CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expenses incurred for services or supplies to be considered as *covered vision expense*.

1. You must incur this expense while you are covered under this *plan*. An expense is incurred on the date you receive the service or materials for which the charge is made.

2. The expense must be for a routine care of the eye, not for surgery or medical care.

3. The expense must be for a vision service or materials included in VISION CARE THAT IS COVERED. Additional limits on *covered vision expense* are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a vision service or materials listed in VISION CARE THAT IS NOT COVERED. If the service or materials are partially excluded, then only that portion which is not excluded will be considered *covered vision expense*.

5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

6. All services and materials must be ordered by a licensed ophthalmologist, optometrist or dispensing optician.

## VISION CARE THAT IS COVERED

Subject to the Vision Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under VISION CARE THAT IS NOT COVERED, the *plan* will provide benefits for the following services and materials:

**Elective Contact Lenses.** You have an allowance per *benefit year* toward cosmetic contact lenses selected in lieu of the eyeglass lens benefit. If you choose contact lenses that cost more than the *plan* allowance, you are responsible for the difference in cost. If you choose to receive contact lenses during a *benefit year*, no benefits will be paid for lenses during that same *benefit year*.

**Frames.** The *vision care provider* will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. If you go to a *network vision care provider* and you choose frames that cost more than the benefit maximum shown under SUMMARY OF BENEFITS: VISION CARE BENEFIT MAXIMUMS, your cost will be based on a discounted arrangement.

**Lenses.** The *vision care provider* will order the proper lenses necessary for your visual welfare. The *vision care provider* will verify the accuracy of the finished lenses. Covered lenses include plastic (CR39):

1. Single vision;
2. Bifocal;
3. Trifocal (FT25-28); or
4. Progressive lenses.

Benefits include factory scratch coating. Photochromic and polycarbonate lenses prescribed for anyone under age 19 are covered in full. All other coatings, other lens materials and treatments are not covered.

You will be responsible for amounts in excess of the Vision Care Benefit Maximum.

**Non-Elective Contact Lenses.** Non-elective lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit per *benefit year*. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

1. Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
2. Keratoconus - unusual cone-shaped thinning of the cornea of the

eye which usually occurs before the age of 20 years; or

3. High Ametropia - unusually high levels of near sightedness, far sightedness, or

4. Anisometropia - when one eye requires a much different prescription than the other eye.

**Vision Examination.** A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of correction eyewear where indicated. This does not include contact lens fitting fee.

## VISION CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

**Cosmetic Options.** Blended lenses/no line; oversize lenses; progressive multifocal lenses; photochromatic lens; tinted lenses, except as specifically stated in the "lenses" provision of VISION CARE THAT IS COVERED; coated lenses, except factory scratch coating; cosmetic lenses or processes; and UV-protected lenses.

**Crime or 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.

**Excess Amounts.** Any amounts in excess of *covered vision expense*.

**Experimental or Investigative.** Any *experimental* or *investigative* services or materials.

**Eye Surgery.** Any medical or surgical treatment of the eyes and any diagnostic testing. 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 actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. The *plan* will not cover payment for

these services if you are not required to pay for them or they are given to you for free.

**Hospital Care.** Inpatient or outpatient hospital vision care.

**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames, unless you have reached a new benefit period.

**Non-Licensed Vision Care Providers.** Treatment or services rendered by non-licensed *vision care providers* and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed *vision care provider* under the supervision of a licensed physician or licensed *vision care provider*, except as specifically provided or arranged by the *claims administrator*.

**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

**Not Specifically Listed.** Services not specifically listed in this *plan* as covered services.

**Orthoptics.** Orthoptics or vision training and any associated supplemental testing.

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

**Routine Exams or Tests.** Routine exams or tests required for employment.

**Safety Glasses.** Safety glasses and accompanying frames.

**Services of Relatives.** Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.

**Sunglasses.** Sunglasses and accompanying frames.

**Uninsured.** Services received before your *effective date* or after your coverage ends.

**Voluntary Payment.** Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage.

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

## GENERAL PROVISIONS

**Providing of Care.** We are not responsible for providing any type of vision care, nor are we responsible for the quality of any such care received.

**Independent Contractors.** The *claims administrator's* relationship with providers is that of an independent contractor. Opthalmologists, optometrists and dispensing opticians are not the *claims administrator's* agents nor are they or any of their employees, an employee or agent of any *vision care provider* of any type.

**Non-Regulation of Providers.** The benefits of this *plan* do not regulate the amounts charged by providers of vision care, except to the extent that rates for covered services are regulated with *network vision care providers*.

**Terms of Coverage**

1. In order for you to be entitled to benefits under the *plan,* both the *plan* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without your consent or concurrence.

**Nondiscrimination.** No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

**Protection of Coverage.** We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the *plan*.

**Free Choice of Provider.** This *plan* in no way interferes with your right as a *member* entitled to vision care benefits to select a *vision care provider.* You may choose any *vision care provider* which provides care covered under this *plan,* and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

**Expense in Excess of Benefits.** We are not liable for any expense you incur in excess of the benefits of this *plan*.

**Benefits Not Transferable.** Only *members* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

**Notice of Claim and Proof of Loss.** You or the *vision care provider* must send the *claims administrator* an itemized bill within 90 days of the date you receive the service or supply for which claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, the *plan administrator* is not liable for the benefits of the *plan* if you do not file claims within the required time period. The *plan administrator* will not be liable for benefits if the *claims administrator* does not receive written proof of loss on time. Canceled checks or receipts are not acceptable.

**Timely Payment of Claims.** Any benefits due under this *plan* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonably necessary additional information the *claims administrator* may require to determine our obligation.

**Payment to Providers.** The *plan* will pay the benefits directly to *network vision care providers*. Also, the *plan* will pay *out-of-network vision care providers* directly when you assign benefits in writing. These payments will fulfill our obligation to you for those covered services.

**Right of Recovery.** Whenever payment has been made in error, the *claims administrator* will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the *claims administrator* will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if the *claims administrator* pays your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, the *claims administrator* may collect such amounts directly from you. You agree that the *claims administrator* has the right to recover such amounts from you.

The *claims administrator* has oversight responsibility for compliance with provider and vendor and subcontractor contracts. The *claims administrator* may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made

from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

The *claims administrator* has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The *claims administrator* will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The *claims administrator* may not provide you with notice of overpayments made by them or you if the recovery method makes providing such notice administratively burdensome.

**Workers' Compensation Insurance.** The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

**Liability to Pay Providers.** In the event that the *plan* does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the *plan*.

**Renewal Provisions.** The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

**Financial Arrangements with Providers.** Under arrangements with some health care providers and suppliers (hereafter referred to together as "Providers") certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, vision services rebates, may be based on utilization of specific Providers for specified vision services rendered to all persons who have coverage through a similar vision program provided or administered by Anthem Blue Cross Life and Health or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

## DEFINITIONS

The meanings of key terms used in this *plan booklet* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your *plan booklet*, you should refer to this section.

**Benefit year** is a 12-month period that determines the application of your benefits, such as the accumulation toward satisfaction of the annual deductible and accumulation toward annual benefit limitations or maximums. Your *benefit year* starts at the first of the month in which your *coverage period* begins.

**Child** meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

**Claims administrator** refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan.*

**Contributory Insurance; non-contributory insurance.** Contributory insurance is insurance for which the *plan administrator* has the right to require your contributions. *Non-contributory insurance* is insurance for which the *plan administrator* does not have the right to require your contributions. The Summary of Benefits shows whether insurance under a coverage is *contributory insurance* or *non-contributory insurance*.

**Coverage period** is the period during which a student and his or her dependents are eligible to receive the benefits of this *plan.*

**Covered vision expense** is the expense you incur for a covered service or materials, but not more than the maximum amounts described in YOUR VISION CARE BENEFITS: HOW COVERED VISION EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or materials.

**Dependent** meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

**Domestic partner** meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

**Effective date** is the date your coverage begins under this *plan*.

**Experimental** procedures are those that are mainly limited to laboratory and/or animal research.

**Group** refers to the entity to which we have issued this coverage agreement. The name of the *group* is the UNIVERSITY OF CALIFORNIA STUDENT HEALTH INSURANCE PLAN.

**Insured person** is the *insured student* or *insured dependent*.

**Insured student (student)** is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible dependents.

**Investigative** procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

**Negotiated rate** is the amount *network vision care providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Preferred Provider Organization Plan Participating Agreements.

**Out-of-network vision care provider** is a provider which does not have a Preferred Provider Agreement with the *claims administrator* at the time services are rendered.

**Network vision care provider** is a provider which has a Preferred Provider Organization Plan Participating Agreement in effect with the *claims administrator* at the time services are rendered. Network vision care providers agree to accept the *negotiated rate* as payment for covered services.

**Plan** is the set of benefits described in this booklet and in the amendments to this booklet (if any). This *plan* is subject to the terms and conditions of the coverage agreement we have issued to the *group*. If changes are made to the *plan*, an amendment or revised booklet will be issued to the *group* for distribution to each *insured student* affected by the change

**Plan Booklet (plan booklet)** is this written description of the benefits provided under the *plan*.

**Plan year** is the start and end date of the UC SHIP *plan year*, used for the purposes of the *plan* contract, financial management and data reporting.

**Prior plan** is a plan sponsored by the *plan administrator* which was replaced by this *plan* within 60 days. You are considered covered under the *prior plan* if you: (1) were covered under the *prior plan* on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

**Spouse** meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

**Vision care provider** is an ophthalmologist, optometrist or dispensing optician who is licensed to practice vision care, is rendering a service within the scope of the license and is providing a service for which benefits are specified in this *plan booklet*.

**We (us, our)** refers to *Plan Administrator*.

**You (your)** refers to the *insured student* and dependents who are enrolled for benefits under this *plan*.

# Get help in your language

**Curious to know what all this says? We would be too. Here's the English version:**

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from the claims administrator's language assistance program, documents are made available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

**Spanish**
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

**Arabic**
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك
للمساعدة(TTY/TDD: 711).

**Armenian**
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

**Chinese**
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

**Farsi**
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به

شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

**Hindi**
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

**Hmong**
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

**Japanese**
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

**Khmer**
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

**Korean**
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

**Punjabi**
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

**Russian**
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

**Tagalog**
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng

Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

**Thai**
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

**Vietnamese**
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

**It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html