

# **Benefit Booklet**

(Referred to as “Booklet” in the following pages)

## **Blue View Vision Plan**

**University of California Student Health Insurance Plan**



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 capitalized 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: [myucship.org](http://myucship.org)**

## 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 to 1-866-940-8306 or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21215 Burbank Boulevard, 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: [myucship.org](http://myucship.org)**

Claims Administered by:

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. UC College of the Law San Francisco
    - iii. Irvine
    - iv. Los Angeles
    - v. Merced
    - vi. Riverside
    - vii. San Diego
    - viii. San Francisco
    - ix. Santa Barbara
    - x. 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 campuses 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 the 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, Santa Barbara 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 Academic Health Plans at 1-855-427-3206.
  - b. All non-registered graduate and undergraduate students at Davis, Merced, and Santa Cruz; Los Angeles and Santa Barbara graduate students and Riverside undergraduates who are on a Planned Educational Leave (PELP); graduate students at Los Angeles, Riverside, San Diego, San Francisco, Santa Barbara; Irvine 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 Academic Health Plans at 1-855-427-3206.
  - c. 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 Academic Health Plans (AHP) at 1-855-427-3206. 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:

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

## 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 Dependents 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 Academic Health Plans 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. Please see your campus website for the coverage periods.

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 **AHP at 1-855-427-3206, 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 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 Academic Health Plans at 1-855-427-3206, 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 Academic Health Plans 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 AHP 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 Academic Health Plans will not delay or prevent termination of coverage for the Spouse, Domestic Partner or Child. If the student notifies Academic Health Plans 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 Academic Health Plans at 1-855-427-3206, 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 at 866-940-8306 or you may also search for a Network Vision Care Provider using the "Provider Finder" function on our website at [myucship.org](http://myucship.org)

**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.

Benefits	Network	Out-of-Network	Frequency
<b>Routine Eye Exam</b> A comprehensive eye examination	\$10 Copayment	Up to \$49 reimbursement	Once every Benefit Year
<b>Eye Frames</b> One pair of eyeglass frames	\$120 allowance, then 20% off any remaining balance	Up to \$50 reimbursement	Once every Benefit Year
<b>Eyeglass Lenses (instead of contact lenses)</b> One pair of standard plastic prescription lenses:			
• Single Vision lenses	\$25 Copayment	Up to \$35 reimbursement	Once every Benefit Year
• Bifocal lenses	\$25 Copayment	Up to \$49 reimbursement	Once every Benefit Year
• Trifocal lenses	\$25 Copayment	Up to \$74 reimbursement	Once every Benefit Year
<b>Eyeglass Lens Enhancements</b> When obtaining covered eyewear from a Blue View Vision Insight provider, you may add any of the following lens enhancements at no extra cost:			
• Transition lenses (for a child under age 19)	No Copayment	Not Covered	Once every Benefit Year
• Standard polycarbonate (for a child under age 19)	No Copayment	Not Covered	Once every Benefit Year
• Factory scratch coating	No Copayment	Not Covered	Once every Benefit Year

<b>Contact Lenses (instead of eyeglass lenses)</b>			
Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
<ul style="list-style-type: none"> <li>Elective conventional (non-disposable)</li> </ul> <p>Or</p>	\$120 allowance, then 15% off any remaining balance	Up to \$92 reimbursement	Once every Benefit Year
<ul style="list-style-type: none"> <li>Elective disposable</li> </ul> <p>Or</p>	\$120 allowance (no additional discount)	Up to \$92 reimbursement	Once every Benefit Year
<ul style="list-style-type: none"> <li>Non-elective (medically necessary)</li> </ul>	No Copayment or Coinsurance	Up to \$250 reimbursement	Once every Benefit Year
<b>Contact lens fit and follow-up</b>			
A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.			
<ul style="list-style-type: none"> <li>Standard contact lens fitting<sup>1</sup></li> <li>Premium contact lens fitting<sup>2</sup></li> </ul>	\$0 copay 10% off retail price, then apply \$40 allowance	Up to \$35 allowance Up to \$35 allowance	Once every Benefit Year

<sup>1</sup> Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

<sup>2</sup> Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

**Note:** In addition to the Copayment 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 Copayments.** There will be no Copayment 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.

## General Information

**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

# You 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 Copayments and Benefit Maximums

After your Copayment is subtracted, benefits will be paid up to the amount of Covered Vision Expense, not to exceed the applicable Vision Care Benefit Maximum. The Copayments 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 electronic 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 Copayment 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 routine care of the eye and not for surgery or medical care.
3. The expense must be for a vision service or materials included Vision Care That is Covered. Additional limits on Covered Vision Expense are located under specific benefits and in the Summary of Benefits.

4. The expense must not be for a vision service or material listed in Vision Care That Is Not Covered. If the service or material is partially excluded, then only that portion which is not excluded will be considered a 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)
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. Ophthalmologists, 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.

**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, copayments 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 start with a capital letter. When any of the terms below are capitalized 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.

**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** 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 our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service 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 مجاناً. 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 मुफ्त 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 ntwm 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

អ្នកមានសិទ្ធិស្នើសុំឯកសារសេវាសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលបានជំនួយ។(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 ਸਰਵਿਸਜ਼ 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, Mail Drop VA2002-N160, Richmond, VA 23279 or by email to [compliance.coordinator@anthem.com](mailto: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>.