

University of California – PPO Outside of California

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Members are also responsible for all costs over the plan maximums. Important information appears in *italics*.



Explanation of Covered Expense

Plan payments apply to the lesser of the charges billed by the provider or the following:

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

Non-PPO Providers & Other Health Care Providers (*includes those not represented in the PPO provider network*)—The customary & reasonable charge for professional services or the reasonable charge for institutional services. When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible (*PPO & Non-PPO calendar year deductibles are exclusive of each other*)

PPO Providers & Other Health Care Providers	\$250/member; \$750/family
Non-PPO Providers	\$500/member/\$1,500 family

Penalty for not obtaining preauthorization where required: \$200/occurrence

Annual out-of-pocket maximums (*PPO & Non-PPO out-of-pocket maximums are exclusive of each other*)

PPO Providers & Other Health Care Providers	\$3,000/member/year; \$9,000/family/year
Non-PPO Providers	\$6,000/member/year; \$18,000/family/year

The following do not apply to out-of-pocket maximums: percentage copays for behavioral health services; prescription drug copays; non-covered expense; non-compliance penalty charges; charges in excess of customary and reasonable charges. After a member reaches the out-of-pocket maximum, the member remains responsible for behavioral health services; prescription drug copays; non-compliance penalties; costs in excess of customary and reasonable charges; costs in excess of the covered expense, non-covered expense.

Lifetime Maximum \$2,000,000/member

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
-------------------------	------------------------------	----------------------------------

Hospital Medical Services (*preauthorization required; waived for emergency admissions*)

➤ Semi-private room, meals & special diets, & ancillary services	20%	40%
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	20%	40%

Ambulatory Surgical Centers (*preauthorization required; waived for emergency admissions*)

➤ Outpatient surgery, services & supplies	20%	40%
---	-----	-----

Skilled Nursing Facility (*preauthorization required*)

➤ Semi-private room, services & supplies (<i>limited to 240 days/calendar year</i>)	20%	40%
---	-----	-----

Hospice Care

➤ Inpatient or outpatient services for members with up to one year life expectancy	20%	20%
--	-----	-----

Home Health Care (*preauthorization required*)

➤ Services & supplies from a home health agency (<i>limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care</i>)	20%	40%
---	-----	-----

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Registered Special Duty Nurse (<i>outpatient only; preauthorization required</i>)	20%	40%
Home Infusion Therapy (<i>preauthorization required</i>)	20%	40%
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services		
Physician Medical Services		
➤ Office & home visits	20%	40%
➤ Hospital & skilled nursing facility visits	20%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	20%	40%
Diagnostic X-ray & Lab (<i>including mammograms, Pap smears, & prostate cancer screenings</i>)	20%	40%
Preventive Care		
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam		
- <i>birth to age 6</i>	No copay	No copay
- <i>age 7 & older</i>	20%	40%
	<i>(deductible waived)</i>	
➤ Vision Exams (<i>when medically necessary</i>)	20%	Not covered
➤ Hearing Exams	20%	40%
➤ Hearing Aids (<i>\$2,000 maximum; maximum 2 hearing aids every 36 months, analog and digital devices are covered</i>)	50%	50%
➤ Allergy testing & treatment (<i>including serums</i>)	20%	40%
Physical Therapy, Physical Medicine & Occupational Therapy	20%	40%
Chiropractic Services	20%	40%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	20%	20%
Acupuncture		
➤ Services for the treatment of disease, illness or injury	20% ¹	40% ¹
Temporomandibular Joint Disorders (<i>preauthorization required</i>)		
➤ Splint therapy & surgical treatment	20%	40%
Family planning services		
➤ Infertility studies & tests	20%	40%
➤ Tubal ligation	20%	40%
➤ Vasectomy	20%	40%
➤ Counseling & consultation	20%	40%
➤ Elective abortion	20%	40%
Pregnancy & Maternity Care		
➤ Physician office visits	20%	40%
	<i>(deductible waived)</i>	
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion (<i>newborn routine nursery care covered</i>)		
➤ Inpatient physician services	20%	40%
➤ Hospital & ancillary services	20%	40%

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Organ & Tissue Transplants (<i>preauthorization required</i>)		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	Not covered
➤ Physician office visits (<i>including specialists and consultants</i>)	20%	Not covered
➤ Transplant travel expense for an authorized, specified transplant (<i>recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days</i>)		No copay (<i>deductible waived</i>)
MedCall [®]		
➤ A 24-hour service that connects members to a nurse or audio library with a toll-free call; the number is printed on the member's ID card		No copay (<i>deductible waived</i>)
Diabetes Education Programs (<i>requires physician supervision</i>)		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	20%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery	20%	20%
Durable Medical Equipment		
➤ Rental or purchase of DME including dialysis equipment & supplies, & therapeutic shoes & inserts for members with diabetes	20%	20%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies	20%	20%
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%	20%
➤ Autologous blood (<i>self-donated blood collection, testing, processing & storage for planned surgery</i>)	20%	20%
Emergency Care		
➤ Emergency room services & supplies	20%	20%
➤ Inpatient hospital services & supplies	20%	20% first 48 hours; 40% after 48 hours (<i>unless member can't be moved safely</i>)
➤ Ambulatory surgical center services & supplies	20%	20%
➤ Physician services	20%	20%

Mental and Nervous Disorders & Substance Abuse Benefits are provided through United Behavioral Health (UBH) Insurance company. Please refer to the UBH page for details.

The benefits provided in this summary are subject to federal and California laws. In addition to the benefits described above, coverage may include additional benefits required by the member's state of residence. These benefits will be itemized in the Combined Evidence of Coverage and Disclosure Form.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Members residing outside of the PPO service area and members traveling out of the country will be reimbursed at the PPO benefit level. Members are responsible for 20% of the Customary & Reasonable allowance plus the difference between the Customary & Reasonable allowance and billed charges.

Blue Cross PPO— Medical Exclusions and Limitations

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

Experimental or Investigative. Any experimental or investigative procedure or medication.

Crime or Nuclear Energy. Conditions that result from (1) the member's 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 the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Evidence of Coverage (EOC).

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

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, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

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

1. it must be internationally known as being devoted mainly to medical research;
 2. at least 20% of its yearly budget must be spent on research not directly related to patient care;
 3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
 4. it must accept patients who are unable to pay; and
- two-thirds of its patients must have conditions directly related to the hospital's research.

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

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

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

Mental or Nervous Disorders. See United Behavioral Health benefits plan description and EOC for benefits.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

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

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Obesity. Services primarily for weight reduction or the treatment of obesity. This exclusion does not apply to surgical treatment of morbid obesity as determined by us if:

1. Surgical treatment of the obesity is necessary to treat another life-threatening condition also involving the obesity; and
2. It has been documented that non-surgical treatments of the obesity have failed.

Sex Transformation. Procedures to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

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

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specifically provided or arranged by us, or as specified as covered in the EOC.

Food Supplements. Food or dietary supplements, except as specified as covered in the EOC.

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

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

Medical Exclusions and Limitations (continued)

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

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

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

Outpatient Prescription Drugs and Medications. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

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

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

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability – BC Life & Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense

PRESCRIPTION DRUG BENEFITS

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
Retail Pharmacy	
➤ Generic drugs	\$15
➤ Brand name formulary drugs	\$25
➤ Brand name non-formulary drugs ¹	\$40
➤ Contraceptive Devices; Diabetic supplies	No copay
Mail Service	
➤ Generic drugs	\$30
➤ Brand name formulary drugs	\$50
➤ Brand name non-formulary drugs ¹	\$80
➤ Contraceptive Devices; Diabetic supplies	No copay
Non-participating Pharmacies³	50% of average wholesale price schedule plus charges in excess of the schedule <i>(waived in an emergency)</i>
Supply Limits²	
➤ Retail Pharmacy	30-day supply for retail prescriptions except a 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➤ Mail Service	90-day supply

¹When the member's physician has specified "dispense as written" (DAW) for non-formulary drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for non-formulary drugs, the higher copay will apply.

²Supply limits for certain drugs may be different. Please refer to the Summary Plan Description (SPD) for complete information.

³Out of country benefits are limited to FDA-approved medications dispensed by a licensed pharmacy and will be reimbursed according to the copays outlined above.

The Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums.

Prescription Drug Exclusions & Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC

Services or supplies for which the member is not charged

Oxygen

Cosmetics & health or beauty aids

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs. Drugs or medications prescribed for experimental indications

Drugs which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration

Smoking cessation drugs

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles)

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin)

Anorexiant and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Non FDA-approved drugs obtained outside the U.S.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.

Third Party Liability

BC Life & Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

The Power of Blue.SM

BC Life & Health Insurance Company is an Independent Licensee of the Blue Cross Association. The Blue Cross name and symbol are registered service marks of the Blue Cross Association.

BCLife

SC7423 Effective 1/2003 Printed 11/15/2002 Printed 11/15/2002

United Behavioral Health (UBH)

2003 Behavioral Health for PPO Members

Covered Services	In-Network Providers ¹ Member Copay	Out-of-Network Providers Member Copay
Calendar year deductible		
Individual	\$0	\$500
Family	\$0	\$1,500
Annual Out of Pocket Maximums For Mental Health Benefits (Includes Deductible)		
Individual	\$1,500	\$6,000
Family	\$4,500	\$18,000
Lifetime Maximum	N/A	\$2,000,000
Mental Health Outpatient		
Office Visits		
➤ Visits 1-5	No Copay	40%
➤ Visits 6+	\$10 (Waived for Children up to age 6)	40%
Mental Health Inpatient³	No Copay	40% ⁴
Substance Abuse³		
➤ Outpatient	20%	40%
➤ Inpatient	20% (\$100 Calendar Year Deductible) ²	40%
Penalty for non-compliance with treatment plan	30% (Member share increases to 50%)	30% (Member share increases to 70%)
Preauthorization Penalty	N/A	\$200 for failure to notify ⁵

1. In order to be a covered In-Network benefit, all services must be clinically necessary, be provided by a UBH Network Provider, and be pre-approved by a UBH Intake Counselor. "UBH Network Provider" includes providers for which a case-specific accommodation is made by UBH.
2. \$100 Calendar Year Deductible applies to each plan member. Amounts credited to this deductible do not count toward the \$500 out-of-network deductible. Amounts credited toward the \$500 out-of-network deductible do not count toward this deductible.
3. Preauthorization required.

4. Emergency care is treated as In-Network if UBH is notified within 48 hours of admission. Emergency care is defined as “Immediate Mental Disorder Treatment when the lack of treatment could reasonably be expected to result in the patient harming him/herself or another person(s).”
5. Penalty is applied before the member accumulates covered expenses toward the individual deductible and the penalty does not apply toward the individual deductible. If the individual deductible is satisfied, the penalty is applied in addition to the 40% member Copay. Outpatient penalty is applied per course of treatment per covered problem or condition. Inpatient penalty is applied per admission.

Notes

- Out-of-Network outpatient mental health services are not subject to preauthorization, but must be medically necessary/clinically appropriate to be covered and are subject to retrospective review. Expenses determined not medically necessary/clinically appropriate will not be covered.
- The preauthorization penalty applies when preauthorization is not requested. If preauthorization is sought and not approved, no coverage is provided.
- Out-of-Network member Copay is 40% of the “allowed” charges. “Allowed charges” are based on the lesser of Reasonable & Customary or billed charges. Charges in excess of “allowed charges” are not covered.
- In and Out-of-Network member expenses for Substance Abuse do not apply to the Out of Pocket Maximums.
- In-Network and Out-of-Network Annual Out of Pocket Maximums are exclusive of each other.

This is a brief summary of benefits. Please refer to the plan’s benefit booklet for details, requirements, maximums and limits.