University of California
Core Plan
Benefit Summary
Uniform Health Plan Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlights: A description of the prescription drug coverage is provided separately

Effective: January 1, 2015

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible (All providers combined)	$3,000 per individual	
Calendar Year Out-of-Pocket Maximum (Includes the plan deductible)	$6,350 per individual/$12,700 per family	
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non-Participating Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	20%	20%
• Teladoc visit (Teladoc provides access to U.S. board-certified doctors 24/7/365 via phone or online video consults for urgent, non-emergency medical assistance, including the ability to write prescriptions, when you are unable to see your primary care physician. This service is available by calling 1-800-Teladoc (835-2362).)	20%	Not Covered
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	20%	20%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	20%	20%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	20%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar Year Deductible)	20%
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	20%	20%[5]
• Outpatient surgery in a hospital	20%	20%[5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	20%[5]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	20%	20%[5]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	20%	20%[5]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	20%	Not Covered
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	20%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	20%[7]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	20%	Not Covered
Skilled Nursing Facility Benefits[8] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[9]
• Skilled Nursing Unit of a Hospital	20%	20%[7]

EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission	20% (Not subject to the Calendar Year Deductible)	20% (Not subject to the Calendar Year Deductible)
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call the Customer Service number on your Identification card.	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	20%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	20%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Other Durable Medical Equipment	20%	20%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[11]		
• Inpatient Hospital Services	20%	20%[7]
• Residential Care	20%	20%
• Inpatient Physician Services	20%	20%
• Routine Outpatient Mental Health and Substance Abuse Services (includes professional/physician visits)	20%	20%
• Non-Routine Outpatient Mental Health and Substance Abuse Services (includes electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care)	20%	20%
HOME HEALTH SERVICES		
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year)[8]	20%	Not Covered[12]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered[12]
OTHER		
Hospice Program Benefits		
• Routine home care	20%	Not Covered[12]
• Inpatient Respite Care	20%	Not Covered[12]
• 24-hour Continuous Home Care	20%	Not Covered[12]
• General Inpatient care	20%	Not Covered[12]
Chiropractic Benefits[8]		
• Chiropractic Services - (provided by a chiropractor) (Up to 24 visits per calendar year combined with Acupuncture visits)	20%	20%
Acupuncture Benefits[8]		
• Acupuncture by a certificated acupuncturist (Up to 24 visits per calendar year combined with Chiropractic visits)	20%	20%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	20%	20%
Speech Therapy Benefits		
• Office visit	20%	20%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	20%
• Abortion services (Facility charges may apply - see "Hospital Benefits (Facility Services")	20%	20%

Family Planning Benefits		
• Counseling and consulting[2]	No Charge (Not subject to the Calendar Year Deductible)	20%
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	20%
• Vasectomy[10]	20%	20%
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	20%
• Diabetes self-management training (by a registered dietician or registered nurse that are certified diabetes educators)	20%	20%
Care Outside of Plan Service Area		
• Within US: BlueCard Program	Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the Participating level of the local Blue Plan allowable amount when you use a Blue Cross/BlueShield provider.	
• Outside of US: BlueCard Worldwide	All covered services will be eligible for reimbursement when received outside of the US. Please refer to the Participating Provider Tier for covered services and corresponding member liability.	

1 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. Participating providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment as full payment for covered services. Non-Participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.

2 Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

3 Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

4 Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

5 The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-participating hospital is $350 per day. Members are responsible for 20% of this $350 per day, plus all charges in excess of $350.

6 Bariatric surgery is covered when pre-authorized by the Plan. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other Participating provider and there is no coverage for bariatric services from non-Participating Providers. In addition, if prior authorized by the Plan, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further benefit details.

7 The maximum allowed charges for non-emergency hospital services received from a non-Participating hospital is $600 per day. Members are responsible for 20% of this $600 per day, plus all charges in excess of $600.

8 For plans with a Calendar Year medical deductible amount, services with a day or visit limit accrue to the Calendar Year day or visit limit maximum regardless of whether the plan medical deductible has been met.

9 When services are prior authorized, members pay the Participating or non-Participating Provider amount.

10 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

11 Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered under the medical benefits; see hospitalization services for benefit details. Services for acute medical complications of detoxification are accessed through Blue Shield using Blue Shield's Participating Providers or with non-Participating Providers.

12 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Participating Provider copayment.

Plan designs may be modified to ensure compliance with federal requirements.