



# USC Health Insurance Plan for Overseas Students 2008/2009

In addition to dollar and percentage copays, insured persons are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Insured persons are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*.

**Customer service 1 (800) 888-2108**

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## Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the customary & reasonable charge for professional services or the reasonable charge for institutional services.

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**Insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.**

<b>Plan year deductible</b>	\$150/insured person
<b>Lifetime Maximum</b>	\$50,000/insured person
Covered Services	Per Insured Person Copay
<b>Hospital Medical Services</b> ( <i>preauthorization required for inpatient services; waived for emergency admissions</i> )	
➤ Semi-private room, meals & special diets, & ancillary services	100% of Covered Expenses
➤ Outpatient medical care, surgical services & supplies ( <i>hospital care other than emergency room care</i> )	100% of Covered Expenses
<b>Ambulatory Surgical Centers</b> ( <i>preauthorization required; waived for emergency admissions</i> )	
➤ Outpatient surgery, services & supplies	100% of Covered Expenses
<b>Physician Medical Services</b>	
➤ Office & home visits	100% of Covered Expenses
➤ Hospital & skilled nursing facility visits	100% of Covered Expenses
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	100% of Covered Expenses
<b>Diagnostic X-ray &amp; Lab</b> ( <i>including mammograms, Pap smears, &amp; prostate cancer screenings</i> )	100% of Covered Expenses
<b>Physical Medicine</b> ( <i>the combined physical, occupational and manipulative therapy maximum is 26 visits per plan year, 26 visits post surgery only per plan year</i> )	100% of Covered Expenses
<b>Temporomandibular Joint Disorders</b>	
➤ Splint therapy & surgical treatment ( <i>limited to \$1,000/insured person's benefit year</i> )	100% of Covered Expenses
<b>Pregnancy &amp; Maternity Care</b> ( <i>services cover insured person only</i> )	
➤ Physician office visits	100% of Covered Expenses
➤ Prescription drug for elective abortion ( <i>mifepristone</i> )	100% of Covered Expenses
Normal delivery, cesarean section, abortion ( <i>newborn routine nursery care covered when natural mother is the insured employee or enrolled spouse</i> )	
➤ Inpatient physician services	100% of Covered Expenses
➤ Hospital & ancillary services	100% of Covered Expenses

Covered Services	Per Insured Person Copay
<b>Diabetes Education Programs</b> <i>(requires physician supervision)</i> ➤ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	100% of Covered Expenses
<b>Prosthetic Devices</b> ➤ 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 <i>(Wigs covered when hair loss is due to chemotherapy treatments, limit \$1,000)</i>	100% of Covered Expenses
<b>Durable Medical Equipment</b> ➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoes & inserts for insured persons with diabetes	100% of Covered Expenses
<b>Related Outpatient Medical Services &amp; Supplies</b> ➤ Ground or air ambulance transportation, services & disposable supplies medically necessary ➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products ➤ Autologous blood <i>(self-donated blood collection, testing, processing &amp; storage for planned surgery)</i>	100% of Covered Expenses 100% of Covered Expenses 100% of Covered Expenses
<b>Emergency Care</b> ➤ Emergency room services & supplies ➤ Inpatient hospital services & supplies ➤ Physician services	100% of Covered Expenses 100% of Covered Expenses 100% of Covered Expenses
<b>Outpatient Drugs and Medications</b> ➤ Drugs and medications, including oral contraceptives & insulin, when dispensed by a physician or licensed pharmacist	100% of Covered Expenses
<b>Medical Evacuation Benefit for USC Students Studying Overseas in USC program</b> <i>(preauthorization required)</i> <i>When insured person has been hospitalized for at least 5 days &amp; the attending physician approves the insured person being moved to either another medical facility or the insured person's home country. (Limited to \$100,000)</i>	No Copay
<b>Repatriation Benefit for International Students &amp; Students Studying Overseas in USC Programs</b> <i>(preauthorization required)</i> <i>In the event of an insured person's death, payment for the reasonable expenses incurred for preparing returning the bodily remains to the insured person's home country. (Limited to a maximum benefits of \$15,000)</i>	No Copay
<b>Covered Expenses While Studying Overseas Under a USC Sanctioned Program</b> After the plan year deductible has been satisfied, we will pay 100% of Covered Expenses <i>(Maximum benefit of \$50,000).</i>	No Copay <i>(After \$150 deductible has been met)</i>

**This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.**

# Fee-For-Service Medical Plan —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. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

**Crime or Nuclear Energy.** Conditions that result from (1) the insured person'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.

**Uninsured.** Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

**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 insured person claims those benefits.

**Government Treatment.** Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay for them or they are given to the insured person for free.

**Services of Relatives.** Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage.

**Voluntary Payment.** Services for which the insured person is not legally obligated to pay. Services for which the insured person is not charged. Services for which no charge is made in the absence of insurance 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 10% 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
5. 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 insured person 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.** Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

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

**Orthodontia.** Braces and other orthodontic appliances or services.

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

**Hearing Aids or Tests.** Hearing aids, except as specified as covered in the Certificate. Routine hearing tests.

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

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

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

**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.

**Weight Alteration Programs (Inpatient and Outpatient).** Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

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

**Sterilization Reversal.** Reversal of sterilization.

**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.

**Pregnancy and Maternity Care.** A dependent daughter's pregnancy and maternity care.

**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 Certificate.

**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 Certificate.

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

**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, 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 specified as covered in the Certificate. Food or dietary supplements, except as specified as covered in the Certificate.

**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 Certificate.

**Acupuncture.** Acupuncture treatment, except as specified as covered in the Certificate.

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 dermatoses or acupuncture points.

**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 Certificate.

**Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs, medications and insulin, except as specified as covered in the Certificate. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

**Contraceptive Devices.** Contraceptive devices prescribed for birth control, except as specified as covered in the Certificate.

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

**Private Duty Nursing.** Inpatient or outpatient services of a private duty nurse.

**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.**

**Pre-Existing Conditions** – No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. But this limitation does not apply to a child born to or newly adopted by an enrolled employee or spouse, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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

**Coordination Of Benefits** – The benefits of this plan may be reduced if the insured person has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

*The Power of Blue.*<sup>SM</sup>

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**BC Life**