



USC Student Only Health Insurance Plan 2009/2010

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

NOTE:* When an insured person receives Inpatient and Outpatient hospital care services at **USC University Hospital, Children's Hospital, USC/Norris Cancer Hospital, Eff. 12/5/07 BHA Alhambra Hospital (Mental Health and Substance Abuse only)** copay is 10% for covered services..

NOTE: Students must receive their primary care at the Student Health Center. Referrals are **REQUIRED** for outside services.

¹ Preauthorization Deductible \$500

(If services requiring preauthorization are not preauthorized)

² Services denoted by ** indicates that services must be provided by USC network providers for the applicable reimbursement level

Explanation of Covered Expense

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

In-Network Providers—PPO negotiated rates. Insured persons are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-Network 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-Network and Other Health Care Providers, insured persons are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage copay.

USC Plan year deductible – USC Providers \$350/insured person

Anthem Blue Cross Plan year deductible – In-Network Providers \$350/insured person

Anthem Blue Cross Plan year deductible – Non-Network Providers \$700/insured person

Note: Max deductible applied per benefit year is \$700

Out-of-Pocket Maximums

USC Providers \$3,500/plan year/insured person

Anthem Blue Cross In-Network Providers & Other Health Care Providers \$3,500/plan year/insured person

Anthem Blue Cross Non-Network Providers \$7,000/plan year/insured person

The following do not apply to out-of-pocket maximums: preauthorized and amounts above the customary & reasonable charges for PPO non-covered expense. After an insured person reaches the out-of-pocket maximum, the insured person remains responsible for dollar penalties, and for non-PPO providers & other health care providers, costs in excess of the covered expense.

Lifetime Maximum \$500,000/insured person

Covered Services	In-Network per Insured person Copay		Non-Network: per Insured person Copay
	USC	Prudent Buyer	
Hospital Medical Services			
➤ Semi-private room, meals & special diets, & ancillary services <i>(preauthorization required)</i>	10%** ²	20%	50%
➤ Surgical services & supplies <i>(preauthorization required) (hospital care other than emergency room care)</i>	10%** ²	20%	50%
➤ Outpatient medical care	10%	20%	50%
Ambulatory Surgical Centers			
➤ Outpatient surgery, services & supplies	10%	20%	50%
Skilled Nursing Facility <i>(preauthorization required; (must be admitted within 24 hours of hospital confinement)</i>			
➤ Semi-private room, services & supplies		20%	50%

Covered Services	In-Network per Insured person Copay	Non-network per Insured person Copay	
Hospice			
➤ Inpatient or outpatient services for insured persons with up to six months life expectancy (<i>limited to \$4,000/lifetime for all inpatient & home hospice service; family bereavement counseling limited to a maximum of 15 visits during 6-month period following death</i>)	20%	20%	
Home Health Care (preauthorization required)			
➤ Services & supplies from a home health agency (<i>limited to 100 visits/plan year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care</i>)	20%	50%	
Physician Medical Services²			
<i>Please see NOTE above</i>			
➤ Office visit co-pay for USC physicians only with referral (deductible is waived)	\$30**2	20%	50%
➤ Mental Health Parity/Non Parity 10% copay (deductible waived) up to a maximum copay of \$30 per visit (MD, PhD, MFCC, MSW) All other services, for example, lab, x-rays, etc., are subject to your plan year deductible and copay.	10%	10%	50%
➤ Immunization (<i>USC will limit all immunizations to \$300 maximum benefit per plan year</i>) Waive deductible for immunizations ONLY at the USC Student Health Center.	10%**2	20%	Not covered
➤ Allergy Treatment	10%**2	20%	50%
➤ Hospital & skilled nursing facility visits	10%**2	20%	50%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%**2	20%	50%
Dental Expenses			
➤ Accidental Dental Injury Expense (<i>services must be received within 12 months from date of accident</i>)	10%	10%	
Durable Medical Equipment (preauthorization required for equipment costing more than \$500)			
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoes & inserts for insured persons with diabetes	20%	50%	
Diagnostic X-ray & Lab (including mammograms Pap smears & prostate cancer screenings)			
MRI, CT scan, PET scan & Nuclear cardiac scan (subject to utilization review)	USC 10%**2	Prudent Buyer 20%	50%
Diabetes Education Programs (requires physician supervision)			
Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training)	USC 10%**2	Prudent Buyer 20%	50%
Physical Medicine / Occupational Therapy			
(<i>Chiropractic maximum is 26 visits per plan year, 26 additional visits post surgery only per plan year.</i>)	\$15/visit (deductible waived)	50%	
Acupuncture			
➤ Services for the treatment of disease, illness or injury (<i>limited \$500/plan year</i>)	20%	50%	
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.)			
Pregnancy & Maternity Care (services cover insured person only)			
➤ USC Physicians only office visits (deductible waived)	\$30**2	20%	50%
Normal delivery, cesarean section, complications of pregnancy & abortion			
➤ Inpatient physician services	10%**2	20%	50%
➤ Hospital & ancillary services	10%	20%	50%
Temporomandibular Joint Disorders			
➤ Splint therapy & surgical treatment (<i>limited to \$1,000/plan year</i>)	20%	50%	

Covered Services	In-Network per Insured person Copay	Non-network per Insured person Copay	
Organ & Tissue Transplants			
Transplant travel expense for an authorized, specified transplant at a Center of Expertise (COE). All services must be pre-authorized.	No copay	No copay	
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	50%	
➤ Physician office visits (including specialists and consultants)	20%	50%	
Medcall®			
A 24-hour service that connects insured persons to a nurse or audio library with a toll-free call; the number is printed on the insured person's ID card	No copay (deductible waived)	No copay (deductible waived)	
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. Wigs covered when hair loss is due to chemotherapy treatments, limit \$1,000.	20%	20%	
Related Outpatient Medical Services & Supplies			
➤ Ground or air ambulance transportation, services & disposable supplies when medically necessary	10%	10%	
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%	50%	
➤ Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	10%	50%	
Emergency Care			
➤ Emergency room services & supplies	10%	10%	
➤ Inpatient hospital services & supplies	10%	10%	
➤ Ambulatory surgical center services & supplies	10%	10%	
➤ Physician services	10%	10%	
Mental or Nervous Disorders and Substance Abuse			
➤ Facility-based care included physician visits (preauthorization required; waived for emergency admissions; services limited to 30days/plan year)	USC 10%**2	Prudent Buyer 20%	50%
➤ Outpatient physician visits for psychotherapy & psychological testing (limited to 25 visits/plan year)	10%**2	10%	50%
➤ Mental Health Parity/Non Parity 10% copay (deductible waived) up to a maximum copay of \$30 per visit (MD,PhD,MFCC,MSW)			
These exclusions, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive maximum benefits, services must be rendered by an Anthem Blue Cross behavioral health provider. Please see the certificate for complete information			
Medical Evacuation Benefits for USC Students Studying Overseas in USC Programs (preauthorization required)			
When insured person has been hospitalized for at least 5 days & 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)		No Copay	
Repatriation Benefit for International Students & Students Studying Overseas in USC Programs (preauthorization required)			
In the event of a 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 benefit of \$15,000)		No Copay	
Covered Expenses While Studying Overseas Under a USC Sanctioned Program			
After the plan year deductible has been satisfied, we will pay 100% of Covered Expenses (Maximum benefit of \$50,000).		No Copay (After \$150 deductible has been met)	

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.

USC Student Health Insurance 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.

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.

Not Covered. 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 Evidence of Coverage (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. 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 CERTIFICATE.

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 insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the CERTIFICATE.

Voluntary Payment. Services for which the insured person 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 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

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.

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 CERTIFICATE. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the CERTIFICATE.

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

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, 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.

Obesity. Services primarily for weight reduction or the treatment of obesity. This exclusion does not apply to surgical treatment of morbid obesity, as determined, and if the treatment is authorized in advance as medically necessary and appropriate.

Sex Transformation. Procedures or treatments 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.

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 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.

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 CERTIFICATE.

Food Supplements. 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 dermatomes 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 or medications and insulin, except as specified as covered in the CERTIFICATE. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

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.

Third Party Liability – Anthem Blue Cross Life and 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, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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