

USF Health Plans



Blue Cross PPOSM P3- Modified (Prudent Buyer 250-20/90/70) for USF

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.

Plan maximums and other important information appear 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 ALLOWED AMOUNT & ACTUAL CHARGES, AS WELL AS ANY DEDUCTIBLE & PERCENTAGE COPAY.

Calendar year deductible for all providers	\$250/member; \$750/family	
Deductible for non-Blue Cross PPO hospital emergency admission)	\$500/admission (<i>waived for</i>)	
Deductible for non-Blue Cross PPO hospital, emergency admission) if services not preauthorized by Review Center	\$250/admission (<i>waived for</i>)	
Deductible for emergency room services from ER)	\$50/visit (<i>waived if admitted directly</i>)	
Stop Loss Maximums per Individual	\$8,000 in total Blue Cross payments	
The following do not apply to the stop loss maximums: amounts paid for mental or nervous disorders & substance abuse; non-covered expense. After a member reaches the stop loss maximums, the member remains responsible for dollar copays; percentage copays for mental or nervous disorders & substance abuse; and, for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	\$2,000,000/member	
Covered Services	PPO: Per	Non-
PPO: Per		
Copay	Member Copay	Member
Hospital Medical Services (<i>preauthorization required; waived for emergency admissions</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	10%	30% ¹
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	10%	30% ¹
Ambulatory Surgical Centers (<i>preauthorization required; waived for emergency admissions</i>)		

➤ Outpatient surgery, services & supplies (\$350/day)	10%	30% (limited to
Skilled Nursing Facility (preauthorization required)		
➤ Semi-private room, services & supplies (medical conditions & severe mental disorders limited to 100 days/calendar year; treatment of substance abuse limited to 30 days/calendar year)	10%	30%
Hospice Care		
➤ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services		20% ²
¹ For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.		
² These providers are not represented in the Blue Cross PPO network.		
Home Health Care (preauthorization required)		
➤ Services & supplies from a home health agency (limited to 120 visits per 12 month period , one visit by a home health aide equals four hours or less; not covered while member receives hospice care)	10%	30%
Home Infusion Therapy (preauthorization required)		
➤ Includes medication, ancillary services & supplies; \$600/day) caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% (limited to
Physician Medical Services		
➤ Office & home visits	\$20/visit⁴	30%
➤ Hospital & skilled nursing facility visits	10%	30%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
Diagnostic X-ray & Lab (including mammograms, Pap smears, & prostate cancer screenings)	10%	30%
Well Baby & Well-Child Care for Dependent Children (age 19 & over, there is a \$250/calendar year maximum)		
➤ Routine physical examinations and most immunizations and associated lab/X-Ray	10%	30%
➤ Immunizations for Hepatitis B & Varicella Zoster (Chicken Pox) (ages 7 through 18) \$12/immunization)	10%	30% (limited to
Preventive Care for Members Ages Employee and Spouse		
➤ Routine physical exams, appropriate immunizations, associated X-ray & lab, annual OB/GYN exams <i>waived</i> (limited to \$250/calendar year)	No copay (deductible waived)	No copay (deductible
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (limited to \$25/visit) 24 visits/calendar year; additional visits may be authorized)	10%	30% (limited to
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	10%	10% ¹
Acupuncture		
➤ Services for the treatment of disease, illness or injury (limited to \$25/visit & 12 visits/calendar year)	10% ²	30% ²
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	10%	10% ¹
Pregnancy & Maternity Care		

<i>(services cover subscriber, spouse & dependent daughters)</i>		
➤ Physician office visits	10%	30%
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion (<i>newborn routine nursery care covered when natural mother is subscriber or spouse</i>)		
➤ Inpatient physician services	10%	30%
➤ Hospital & ancillary services	10%	30% ³
Organ & Tissue Transplants (<i>preauthorization required; specified organ transplants covered only when performed at a Center of Expertise [COE]</i>)		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		10%
➤ Physician office visits (<i>including specialists and consultants</i>)		10%
<p>¹Professional services that may be available from Blue Cross PPO network providers, but would usually be available from providers whose specialties are not represented in the Blue Cross PPO network, are payable at the higher reimbursement level of the plan.</p> <p>²Acupuncture 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.).</p> <p>³For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.</p> <p>⁴The dollar copay applies only to the visit itself. Additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery).</p>		
Organ & Tissue Transplants (continued)		
➤ Transplant travel expense for an authorized, specified transplant at a COE (<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 ⁴ (<i>deductible waived</i>)	30%
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	10%	30%
Durable Medical Equipment		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoes & inserts for members with diabetes	10%	30%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		20% ¹
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20% ¹
➤ Autologous blood (<i>self-donated blood collection, testing, processing & storage for planned surgery</i>)		20% ¹

Emergency Care

➤ Emergency room services & supplies <i>(\$50 deductible waived if admitted)</i>	10%	10%
➤ Inpatient hospital services & supplies 48 hours; 30% ² after 48 hours <i>(unless member can't be moved safely)</i>	10%	10% first
➤ Ambulatory surgical center services & supplies	10%	10%
➤ Physician services	10%	10%

Mental or Nervous Disorders

➤ Facility-based care <i>(preauthorization required; waived for emergency admissions; services limited to \$500/day)</i>	10% ³	30% ^{2,3}
➤ Inpatient or outpatient physician visits for psychotherapy & psychological testing <i>(limited to \$50/visit PPO and \$25/visit non-PPO)</i>	10% ³	30% ³

Substance Abuse

➤ Facility-based care <i>(preauthorization required; waived for emergency admissions; services limited to \$500/day & 30 day Professional/combined in &out/per calendar year; 30 days/calendar year(limit does not apply to inpatient detoxification)</i>	10%	30% ²
➤ Inpatient or outpatient physician visits <i>(limited to \$50/visit PPO & 25 visits/non-PPO & 50 visits /combined in &outs per calendar year)</i>	10%	30%

¹These providers are not represented in the Blue Cross PPO network.

²For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

³These 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 a Blue Cross behavioral health provider. Please see the EOC for complete information.

⁴The dollar copay applies only to the visit itself. Additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

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.

Blue Cross PPO—Prudent Buyer 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.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

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 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 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. 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 EOC.

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.

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

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, 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 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 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.

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. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, 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.

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 Condition Exclusion – 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 member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

Third Party Liability – Blue Cross of California 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.



Rx 14 Prescription Drug Benefits

At Blue Cross of California, we know that prescription drugs are the fastest-rising item of your total health care benefits cost.

Reasons for the spiraling costs of prescription drugs are varied: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

Getting a Prescription Filled at a Participating Pharmacy

To get a prescription filled, you need only take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copay – will be determined by whether the drug is brand-name or generic medication and whether it is a preferred or non-preferred medication.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

Our Preferred Drug Program (PDP) encourages the usage of certain, lower-cost, but equally effective, prescription medications (preferred drugs) in place of higher-cost medications (non-preferred drugs). The non-preferred list contains medications that require your physician's approval before they can be substituted for a preferred medication. By allowing this substitution, the PDP helps you better manage the increasing cost of prescription drugs while still maintaining your access to safe and effective medications.

The following chart illustrates the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	\$10.00
Brand name	\$20.00

Finding a Participating Pharmacy

Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by going to our Web site at www.bluecrossca.com.

An Extensive Network

Besides saving you money, our extensive network of pharmacies offers you easy accessibility.

- In California there are over 5,100 retail pharmacies. This accounts for nearly 95% of retail pharmacies in the state, including all major chains.
- Nationwide there are more than 61,000 chain and independent pharmacies.

Using a Participating Pharmacy

You can substantially control the cost of your prescription drugs by using our extensive network of participating pharmacies. Participating pharmacies have agreed to charge a discounted price or “negotiated rate” and pass along this savings to you.

Using a Non-Participating Pharmacy

If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. The pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

The following chart illustrates potential increased out-of-pocket expenses for going to a non-participating pharmacy:

	Out-of-pocket costs using a participating pharmacy	Out of pocket costs using a non-participating pharmacy
Pharmacy's normal charge for brand-name drug	\$50.00	\$50.00
You are responsible for:	\$20.00 copay	\$20.00 copay plus 50% of the limited fee schedule plus any amounts exceeding the fee schedule
Total out-of-pocket expenses	\$20.00	Expense varies based on the cost of the medication

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our Web site at www.bluecrossca.com.

Submitting a Claim Form

Check to see that all sections of the claim form are completed and mail to:

WellPoint Pharmacy Management
Attn: Blue Cross of California
P.O. Box 4165
Woodland Hills, CA 91365-4165

Mail Service Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our mail service program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Mail Service Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our Web site at www.bluecrossca.com.

Once you complete the form, simply mail it with your copy and prescription in the envelope attached to the Mail Service brochure.

Please note that not all medications are available through the Mail Service Program.

Out-Of-State Prescription Benefits

Our national network of participating pharmacies is available to members when outside California. To find a participating pharmacy, a member can check our Web site or call the toll-free number printed on the ID card. When using a non-participating pharmacy outside of California, the member will follow the same procedures for using a non-participating pharmacy in California as outlined above.

Additional Features That are Part of your Plan

Prior authorization as the term implies, is similar to prior authorization for medical services. Prior authorization applies to a select pool of medications that are often a second line of therapy. To require prior authorization, a drug must meet specific criteria. This criteria is based, among other things, on FDA-approved drug indications, targeted populations and the current availability of effective drug therapies. Prior authorization drugs are not covered unless you receive an approval from Blue Cross of California.

We distribute instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service, at the toll-free number printed on your member ID card, to receive a prior authorization form and/or list of medications requiring prior authorization.

Supply limits are the proper FDA recommendations for prescription medication dosage coupled with our determination of specific quantity supply limits to prescription medications. Although our standard pharmacy plans offer a 30-day supply for medications at a retail pharmacy, the supply limit can vary based on the medication, dosage and usage prescribed by your physician. For example, the supply limit for antibiotics used to treat an infection (e.g., 14 pills to be taken twice a day for one week) is different than blood pressure medication taken on a routine basis (e.g., 120 pills to be taken twice a day for 60 days). By adhering to specified supply limits, members are assured of receiving the appropriate amount of medication.

Programs for Member's Special Health Needs

We recognize that some of our members have unique health care needs requiring special attention. That's why we developed programs exclusively for them. Our additional medical management programs work in synergy with our pharmacy drug program to help members better manage their health care on an ongoing basis.

Diabetic members can receive **free glucometers** so that they can effectively and conveniently monitor their glucose levels.

Seniors can better monitor their chronic diseases and multiple medications through our **seniors-at-risk program**. This program reduces the possibility of toxic drug interactions, and curtails distribution of medications that may adversely affect the senior's chronic condition.

Asthmatic members and their families can take advantage of our program to better control the frequency and severity of the disease.

Members who take multiple prescription medications can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction.

For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card.

Please refer to your Combined Evidence of Coverage and Disclosure Form which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
Participating Retail Pharmacy	
➤ Generic drugs	\$10
➤ Brand name drugs	\$20
Mail Service	
➤ Generic drugs	\$10
➤ Brand name drugs	\$20
Non-participating Pharmacies	<i>Member pays the above copay plus:</i>

50% of the maximum amount allowed & costs in excess of the maximum amount

Supply Limits¹

- Retail Pharmacy
(participating and non-participating) 30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copy; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
- Mail Service 60-day supply

¹Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

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 and are subject to the brand name copay.
- 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

Any expense for a drug or medication incurred in excess of (a) the Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

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)

Drugs obtained outside the U.S.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Select classes of drugs where non-preferred medications, which have therapeutic alternatives, have shown no benefit regarding efficacy or side effect over preferred drugs; however, this will not apply if the prescriber denotes "dispense as written" or "do not substitute"

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

Blue Cross of California is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Kaiser Foundation Health Plan

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the **Evidence of Coverage** for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum	
For one Member	\$1,500 per calendar year
For an entire Family Unit of two or more Members	\$3,000 per calendar year
Deductible or Lifetime Maximum	
	None
Coordination of Benefits	
	Included
Professional Services (Plan Provider office visits)	
You Pay	
Primary and specialty care visits (includes routine and urgent care appointments)	\$15 per visit
Routine preventive physical exams	\$15 per visit
Well-child preventive care visits (0-23 months)	\$5 per visit
Family planning visits	\$15 per visit
Scheduled prenatal care and first postpartum visit	\$5 per visit
Eye exams	\$15 per visit
Hearing tests	\$15 per visit
Physical, occupational, and speech therapy visits	\$15 per visit
Outpatient Services	
You Pay	
Outpatient surgery	\$15 per procedure
Allergy injection visits	\$3 per visit
Allergy testing visits	\$15 per visit
Immunizations	No charge
X-rays and lab tests	No charge
Health education	\$15 per individual visit No charge for group visits
Hospitalization Services	
You Pay	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
Emergency Health Coverage	
You Pay	
Emergency Department visits	\$50 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	
You Pay	
Ambulance Services	\$50 per trip

Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies:	
Generic items	\$10 for a 100-day supply
Brand name items	\$20 for a 100-day supply
Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our DME formulary	20% Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric care (up to 45 days per calendar year)	No charge
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	\$15 per individual therapy visit \$7 per group therapy visit
Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	\$7 per group therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the <i>Evidence of Coverage</i> .	
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual therapy visits	\$15 per visit
Outpatient group therapy visits	\$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission
Home Health Services	You Pay
Home health care (up to 100 two-hour visits per calendar year)	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge
Chiropractic Services (30 visits per calendar year)	\$10 per visit
Kaiser Permanente contracts with American Specialty Health Plans of California, Inc. (ASH Plans) for chiropractic services. You can obtain services from any participating ASH Plan Chiropractor without a referral from your Kaiser Plan Physician. Your ASH Chiropractor coordinates authorization of all services and claims with ASH Plans directly; you simply pay your copayment at each visit. You can obtain a listing of Participating Chiropractors by calling the ASH Plans Member Services Department at 1-800-678-9133. You may also find a Participating Chiropractor by logging onto the ASH Plans Web site at www.ashcompanies.com	

This above chart is a summary of the most frequently asked-about benefits. For more explanation, please refer to the information provided below:

The Kaiser Foundation Health Plan is a non-profit health maintenance organization (HMO). Its purpose is to arrange necessary medical and hospital service for its members. Cooperating with the health plan are Kaiser Foundation Hospitals and The Permanente Medical Group, Inc., a professional corporation of physicians. The Permanente Medical Group physicians represent the major specialties in medicine. Their offices are located at the Plan facilities.

HOW TO USE THE PLAN

To be eligible for Kaiser coverage, you and your dependents must live within a 30-mile radius of any Kaiser Permanente medical facility in the following 21 counties: Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Napa, Placer, Sacramento, San Francisco, San Joaquin (except the city of Tracy), San Mateo, Santa Clara, Solano, Sonoma, Sutter, Tulare, Yolo and Yuba.

The services described are covered benefits only if and to the extent that they are provided, prescribed or directed by a Plan physician. Most services are provided at no charge to you or at a small fee per office visit with no claim forms to complete. The Plan will not pay charges for services from non-Plan doctors and hospitals, except as otherwise indicated. If, after enrollment, you move out of the Northern California Service Area, you may continue your coverage but the only benefits available to you are emergency services.

HOW DO I RECEIVE CARE?

You are encouraged to choose a personal physician from the Permanente Medical Group physicians. Following enrollment in this plan, you will receive an identification card for each member of your family. Be sure to use the card whenever you telephone your doctor, arrange an appointment, or go to Kaiser Permanente for care. To see a physician, phone the nearest Kaiser Permanente medical facility for an appointment. If your need is urgent, explain your need and the appointment clerk will help you get the necessary service.

In case of emergency, phone or go immediately to the Emergency Department at the nearest Kaiser Permanente Medical Center. Emergency service means necessary health services immediately required for unforeseen illness or injury as determined by Kaiser in accord with generally accepted standards of medical practice. Payment for services received from providers not contracting with Kaiser is limited to emergency service required before the member's medical condition permits transfer or travel to the nearest Kaiser Permanente medical center for care.

HOW DO I FILE A KAISER CLAIM?

There is no need to complete a claim form to receive covered benefits at Kaiser Permanente Facilities. However, filing a claim form is necessary after receiving emergency care at a non-Kaiser hospital. To file a claim complete the following steps:

1. After any emergency hospital admission at a non - Plan facility for which you wish to claim reimbursement, notify Kaiser within 24 hours (or as soon as reasonably possible).
2. Submit a claim for payment or reimbursement of the cost of health care services within 90 days after the beginning of the non-Plan service. Necessary forms are available at any Kaiser Foundation Health Plan office or from the USF Benefits Representative.
3. Send your completed claim form to:

Kaiser Foundation Health Plan
Customer Service — Claims Dept.
P.O. Box 12923
Oakland, CA 94604
1-800-464-4000

HOW LONG DOES IT TAKE?

All claims are acted upon within 45 days after they are received, unless additional information is required. If additional information is needed, you will be advised in writing of what is needed. After receiving the requested information, Kaiser may require additional time, not to exceed 45 days, to examine the claim. At that time, the claim may be paid, partially denied, or completely denied.

WHAT IF MY CLAIM IS DENIED?

If your claim is completely or partially denied, you will receive written notice of the decision. The decision will explain:

- Specific reasons for denial of the claim.
- The plan provision(s) on which the denial is based.
- The claim review procedure. This procedure allows you to request that your denial be reconsidered.

WHAT IS THE KAISER CLAIM REVIEW PROCEDURE?

If a request for payment is denied, you or your authorized representative may appeal the decision.

1. File a written request with the Kaiser Permanente office that denied your request within one year after receiving a negative decision. Your request must explain why you think the decision was in error.
2. You may examine pertinent documents not subject to legal privilege and may submit additional written material for consideration of the appeal.

HOW LONG DOES A KAISER APPEAL TAKE?

Normally, a decision on your appeal will be made within 45 days. However, if you ask to examine documents or submit additional written material, the decision may take longer, but no more than 90 days from the time the request or written material is received. After the appeals procedure is complete, you will receive a written notice stating the decision and the reason for it. The notice will also cite the specific plan provisions on which the decision is based.

HOW DO I ASK FOR ASSISTANCE?

If you have a question or concern about medical service, do not hesitate to ask for assistance. Each Kaiser Medical Center has a Patient Assistance Office whose primary function is to help members who need assistance in obtaining services.

1. Write or visit the Patient Assistance Office at the Medical Center where you receive your care, or phone that office using the telephone number shown in the Kaiser Health Care Directory for that Medical Center.
2. Give complete information so that the Patient Assistant can work with you to resolve your concern in a timely manner.

WHAT IF MY CONCERN IS NOT RESOLVED?

1. If your concern is not resolved satisfactorily, submit a written complaint to the Member Services Representative at the Kaiser Medical Center. Send a copy to the USF Benefits Representative.
2. After your complaint is received, it will be acknowledged within 15 days. You will receive the name of the person who will respond to you within 30 days after the written complaint was submitted.

KAISER MEDICAL FACILITY LOCATIONS

SAN FRANCISCO

San Francisco Medical Center
2425 Geary Blvd.
(415) 202-2000

PENINSULA

Redwood City Medical Center
1150 Veterans Blvd.
(650) 299-2000

So. San Francisco Medical Center
1200 El Camino Real
(650) 742-2000

Mountain View Medical Offices
555 Castro Street
(650) 903-3000

EAST BAY

Antioch Medical Offices
3400 Delta Fair Blvd.
(925) 779-5000

Martinez Medical Center
200 Muir Rd.
(925) 372-1000

Oakland Medical Center
280 W. MacArthur Blvd.
(510) 596-1000
Richmond Medical Offices
901 Nevin Ave.
(510) 307-1555

Walnut Creek Medical Center
1425 S. Main St.
(925) 295-4000

Walnut Creek-Park Shadelands
320 Lennon Lane
(925) 906-2000

SOUTHERN ALAMEDA COUNTY

Fremont Medical Offices
39400 Paseo Padre Parkway
(510) 795-3000

Hayward Medical Center
27400 Hesperian Blvd.
(510) 784-4000

Pleasanton Medical Offices
7601 Stoneridge Dr.
(925) 847-5000

NORTH BAY

Fairfield Medical Offices
1550 Gateway Blvd.
(707) 427-4000

Napa Medical Offices
3285 Claremont Way
(707) 258-2500

Novato Medical Offices
97 San Marin Drive
(415) 899-7400

Petaluma Medical Offices
3900 Lakeville Highway
(707) 762-3900

San Rafael Medical Center
820 Las Gallinas
(415) 444-2000

Santa Rosa Medical Offices
401 Bicentennial Way
(707) 571-4000

Vallejo Medical Center
975 Sereno Dr.
(707) 651-1000

SOUTH BAY

Gilroy Medical Offices
7520 Arroyo Circle
(408) 848-4600

Milpitas Medical Center
770 E. Calaveras Blvd.
(408) 945-2900

Santa Clara Medical Center
900 Kiely Blvd.
(408) 236-6400

San Jose Medical Offices
260 International Circle
(408) 972-3000

Santa Teresa Community
Medical Center
250 Hospital Parkway
(408) 972-7000

SACRAMENTO AREA

Davis Medical Offices
55 Cowell Blvd.
30) 757-7100

Rancho Cordova Medical Offices
10725 International Drive
(916) 631-3000

Roseville Medical Offices
1001 Riverside Ave.
(916) 784-4000

Sacramento Medical Center
2025 Morse Ave.
(916) 973-5000

So. Sacramento Medical Center
6600 Bruceville Rd.
(916) 688-2000

SAN JOAQUIN VALLEY

Fresno Medical Offices
7300 N. Fresno St.
(559) 448-4500

Stockton Medical Offices
7373 West Lane
(209) 476-2000

KAISER PLAN BENEFITS

The following benefits are provided at no charge:

- Hospital services – no limit to the number of covered hospital days. All physician and surgeon services, intensive care/cardiac care, room and board, laboratory and X-ray, anesthetic services, physical therapy (short-term), other necessary services and supplies (including special nursing and administered medications).
- Laboratory and X-ray services.
- Maternity care – hospital services and complications of pregnancy. Please note the out of service area exclusions under the section titled “Emergency Services”.
- Ambulance service – when authorized by a Plan physician.

The following benefits are provided upon payment of a supplemental fee as noted:

There is a limit to the amount of out-of-pocket expenses that you must pay in a calendar year for physical, occupational, speech, rehabilitation, and inhalation therapy; laboratory and X-ray services; the first 20 mental health visits, and professional services provided in medical offices, hospital emergency rooms or during house calls. You must request and keep receipts to prove these charges have been paid. The supplemental fee maximums are updated each year. Contact the nearest Kaiser Plan office for this year’s amounts.

Kaiser Foundation Health Plan provides additional benefits as described in the following text:

KAISER PRESCRIPTION DRUGS

Covered Prescription Drugs

Kaiser Foundation Health Plan covers prescription drugs when obtained from a Plan pharmacy.

- Prescriptions written by a non-Plan physician are not covered, except for dental purposes.

NOTE: *Drugs and medications prescribed for services excluded under this plan are NOT covered. Generic drugs may be used to fill a prescription unless otherwise specified by a prescribing physician.*

- Disposable needles and syringes needed for injecting prescribed medications are provided at no charge.

Limitations

Coverage for drugs and medications used in smoking cessation therapy, including nicotine patches and chewing gum, is limited to one course of treatment per calendar year. These medications are only provided if the member is participating in a Kaiser Permanente behavioral intervention program and the smoking cessation medication prescription is written by a Plan physician. You pay the cost of the behavioral intervention program and 50% of the price per prescription of the smoking cessation medication.

WHAT IS MY PRESCRIPTION COST?

Covered drugs and accessories are provided to you for \$10 for up to a 100 day supply for generic drugs and \$20 for up to a 100 day supply for “brand name”. Refills are provided on the same basis as the original prescription. Internally implanted time-release medications are provided at a charge approximating the aggregate charges that would be paid for an alternative, conventional drug

therapy, but not more than \$200. A list of these medications is available at Health Plan Offices. No refund is given if the medication is removed.

HOW DO I USE THE PRESCRIPTION PLAN?

Covered medications and accessories must be prescribed by a physician or dentist and must be purchased at pharmacies operated by Kaiser Foundation Hospitals or Kaiser Foundation Health Plan, Inc. in Northern California. Each Kaiser Permanente Medical Center has one or more pharmacies from which drugs may be purchased. Refillable prescriptions may be ordered by phone or mail from the pharmacy which originally filled the prescription. All Kaiser Permanente pharmacies provide mail delivery of refill prescriptions. Certain Kaiser Permanente pharmacies offer delivery service for refills. Your pharmacy will give you additional information about prescription refill services.

IMMUNIZATIONS

The following immunizations are provided in Kaiser Foundation Health Plan medical offices at no charge:

- immunizations medically indicated and consistent with accepted medical practice; and
- immunizations approved by the Federal Food and Drug Administration (FDA) for general use before April 1 of last year.

The following immunizations are provided in Kaiser Foundation Health Plan medical offices at a charge of 50% of nonmember rates for the balance of that calendar year and the following year:

- immunizations approved by the FDA for general use after April 1 of last year.

A current list of diseases for which immunizations are covered is available at Health Plan offices.

EYE EXAMINATIONS AND GLASSES

Eye examinations for glasses are provided at \$10 per visit. Exams for contact lenses are available. This charge applies if you already wear contact lenses at the time of your exam. There is an additional fee for contact lenses fitting, however the charge varies according to type of lenses prescribed. For first time exams for contact lenses, the benefit co-pay (\$10.00) is charged.

HEALTH EDUCATION

Health education services for specific conditions, such as diabetic, nutritional and postcoronary counseling, are provided at \$10 per visit. When available, general health education services not addressed to a specific condition, such as weight control classes, smoking cessation classes, and Lamaze or other training in alternative birth techniques, are provided upon payment of a reasonable charge. Education in the appropriate use of Kaiser Foundation Health Plan services, and health education publications which contain instructions on how to achieve and maintain physical and mental health and prevent illness and injury are provided at no charge.

HEARING TESTS AND HEARING AIDS

Hearing tests, including tests to determine the need for hearing correction, are provided at \$10 per visit. Hearing aids, including internally implanted hearing aids, and tests to determine their efficiency are not covered.

TREATMENT FOR ALCOHOL OR DRUG DEPENDENCY

Physician and Professional Services

Treatment and counseling for alcohol or drug dependency are provided in the doctor's office at \$10 per visit. During covered hospitalization, physician services are provided at no charge.

Hospitalization Services

Hospitalization for alcohol or drug detoxification is limited to removal of the toxic substances from the system. When prescribed, hospitalization for medical management of withdrawal symptoms is provided on the same basis as hospitalization for any other covered condition. Your physician may determine the appropriate need for services at a specialized facility and make a referral to such a facility. In that case, the determination and referral are covered, but the cost of the specialized facility's services is not.

Exclusions

The following services are not covered:

- Counseling for a patient or condition that would not be responsive to therapeutic management. This professional judgment is made by the Plan physician.
- Continuation in a course of counseling for patients who are disruptive or physically abusive.
- Methadone maintenance (except for pregnant members).
- Treatment in a specialized alcohol or drug dependency treatment center.
- Services on court order or as a condition of parole or probation unless the services are determined by the attending physician to be necessary and appropriate.

MENTAL HEALTH CARE

Services of Physicians and Other Professional Services in Medical Offices

Up to 20 outpatient mental health visits are provided each calendar year at \$10 per visit. Group therapy is also available. Additional office visits in any calendar year are not covered. Members with Medicare Part B pay \$3 per visit and may receive additional prescribed visits.

Hospital Services

Up to 45 days of prescribed short-term psychiatric hospital care are provided at no charge each calendar year. Members with Medicare Part A receive additional short-term care at no charge. Two days of day care, night care or pass days (days on which the patient returns home at night) count as one day of hospitalization. Inpatient professional care is provided at no charge during any period of covered hospitalization, day care or night care.

Psychological Testing

Prescribed diagnostic psychological testing is provided at 50% of nonmember rates. Members with Medicare Part B receive such testing at no charge. Court-ordered testing and testing for ability aptitude, intelligence or interest are not covered.

EXCLUSIONS

The following mental health services are not covered:

- Services after diagnosis for conditions which in the professional judgment of the attending physician, are not subject to significant improvement through relatively short-term therapy. Such conditions include chronic psychosis, chronic brain syndrome, intractable personality disorder and mental re- For liability reasons and to abide with the regulations imposed by The California State Law and Federal Trade Commission guidelines, Kaiser does not give prescriptions to members to take outside to another provider. This will only be allowed after 120 days of your original fitting and with the approval of your doctor. (That is if the member has followed all the recommendations from the doctor and an eye illness has not developed as a consequence of wearing contact lenses.) Outpatient drug therapy will be provided for these conditions, as appropriate, in the professional judgment of the attending physician.
- Services to patients who, in the professional judgment of the attending physician, are seeking services for other than therapeutic purposes.
- Services on court order as a condition of parole or probation, unless the services are determined by the attending physician to be medically necessary and appropriate.

EXTENDED CARE

Extended Care services include skilled nursing care on a 24 hour per day basis; bed and board; X-ray and laboratory procedures; physical therapy; inhalation therapy; speech therapy; occupational therapy; medical social services; prescribed drugs, medication and medical supplies; appliances and equipment ordinarily furnished by the skilled nursing facility. If extended care services meet the following conditions, up to 100 days of skilled inpatient services are covered at no charge each calendar year:

- medically necessary and above the level of custodial, convalescent, intermediate or domiciliary care;
- ordered by a Plan physician; and
- customarily provided only by skilled nursing facilities.

Exclusions

Care for which a patient does not medically require the care or supervision of a registered nurse 24 hours per day. Examples include custodial, convalescent, intermediate, or domiciliary care.

PHYSICAL THERAPY, INHALATION THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY, AND REHABILITATION THERAPY

Initial and subsequent courses of physical, inhalation, speech and occupational therapy will be provided for up to two months for each prescribed course of treatment. Your attending physician must judge that significant improvement will occur within such two month period. Physical, inhalation, speech, and occupational therapy treatments are provided in Plan medical offices at \$10 per visit. If you receive therapy while you are hospitalized, physical, inhalation, speech and occupational therapy are provided at no charge. During covered hospitalization, prescribed inhalation therapy is provided at no charge. In medical offices or hospital emergency departments, prescribed inhalation therapy is provided at \$10 per visit.

Limitations

Speech therapy is limited to treatment for speech impairments of specific organic origin. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. Rehabilitation treatment for up to two months in a prescribed, organized multi-disciplinary rehabilitation program is provided if the attending physician determines that significant improvement in function is achievable within two months. Treatment in an organized rehabilitation program, whether provided in a hospital, doctor's office or other facility, applies toward the two month limit on treatment. Treatment in a hospital or skilled nursing facility is provided at no charge.

RECONSTRUCTIVE SURGERY

- *To improve physical function*

Reconstructive surgery that will result in significant improvement in physical function is provided subject to payment of any applicable supplemental charges. A Plan physician determines whether reconstructive surgery is medically feasible and likely to result in significant improvement in physical function.

- *After injury or surgery*

Reconstructive surgery to correct a significant disfigurement resulting from an injury or surgery is provided subject to payment of any applicable supplemental charges. A Plan physician will determine the medical feasibility of surgery and whether the surgery can reasonably be expected to correct the condition.

- *After mastectomy*

If all or part of a breast is removed for medical reasons, reconstructive surgery is provided subject to payment of any applicable supplemental charges. A Plan physician will determine whether reconstructive surgery is medically feasible, and the extent to which further reconstructive surgery is necessary.

Prosthetic Devices, Braces, and Durable Medical Equipment

Surgically Implanted Devices

During covered surgery, internally implanted devices (such as pacemakers and hip joints) approved by the Federal Food and Drug Administration (FDA) for general use before April 1 of last year are provided at no charge. Internally implanted devices approved by the FDA after April 1 of last year are provided at a charge of 50% of nonmember rates for the balance of that calendar year and the following year. Internally implanted hearing aids are not covered, except as specified in this section under *Hearing Tests and Aids*.

External Prosthetic Devices

When prescribed by a Plan physician, prosthetic devices and braces, and the fitting and adjustment of these devices, are provided without charge. Kaiser Foundation Health Plan will select the provider or vendor. Repair or replacement is provided without charge, unless necessitated by misuse or loss. Kaiser Foundation Health Plan may replace rather than repair an item at its option. For the purpose of these benefits, prosthetic devices and braces are:

- affixed to the body externally; and

- either required to replace all or any part of any body organ or extremity, or required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part; and
- approved by the FDA for general use on April 1 of last year; and
- intended for repeated use; and
- primarily and customarily used to serve a medical purpose; and
- generally is not useful to a person in the absence of illness or injury.

Exclusions

The following items are not covered:

- Experimental or research devices and appliances.
- Corrective shoes and arch supports.
- Dental appliances.
- Non-rigid appliances and supplies.

Prostheses Following Mastectomy

A prosthetic device following mastectomy is covered if all or part of a breast is surgically removed for medically necessary reasons. Replacement will be made when a prosthesis is no longer functional. Custom made prostheses will be provided when necessary.

Durable Medical Equipment

Durable medical equipment, including oxygen dispensing equipment (and oxygen), used during a covered stay in a hospital or skilled nursing facility is provided at a charge of \$10. When prescribed by a Plan physician, medically necessary durable medical equipment for use in the home (including an institution used as a home) is provided without charge. Kaiser Foundation Health Plan, at its option, will decide to either rent or provide the equipment. You must return or pay the fair market price for the equipment when it is no longer prescribed. Oxygen for use in conjunction with prescribed durable medical equipment is provided without charge. Repair or replacement of durable medical equipment is provided without charge, unless necessitated by misuse or loss. For the purpose of this benefit, durable medical equipment is equipment which:

- is intended for repeated use, and
- is primarily and customarily used to serve a medical purpose, and
- Generally is not useful to a person in the absence of illness or injury.

Exclusions

The following equipment is not covered:

- Comfort and convenience equipment.
- Disposable supplies.
- Exercise and hygiene equipment.
- Electronic monitors of the function of the heart or lungs except apnea monitors for newborns.
- Devices to perform medical tests on blood or other body substances or excretions except blood glucose monitors for diabetics.
- Corrective shoes and arch supports.
- Dental Appliances.
- Experimental or research equipment.

- Devices not medical in nature such as sauna baths and elevators, or modifications to the home or auto.

HEMODIALYSIS, ORGAN TRANSPLANTS, AND BONE MARROW TRANSPLANTS

Hemodialysis

While you are hospitalized, services relating to renal dialysis are provided at no charge. Equipment, training and medical supplies required for home dialysis are provided at no charge. Services in the doctor's office relating to renal dialysis are provided at \$10 per visit.

Organ Transplants

The Plan covers the reasonable medical and hospital expenses of a donor or prospective donor, or other directly related expenses for obtaining a donor organ. While you are hospitalized, services relating to covered organ transplants are provided at no charge. Services in the doctor's office relating to covered organ transplants are provided at \$5 per visit. Experimental or investigational organ transplants are not covered. Artificial organs and their implantation are NOT covered.

Bone Marrow Transplants

The Plan covers the reasonable medical and hospital expenses of a donor or prospective donor. While you are hospitalized, services relating to covered bone marrow transplants are provided at no charge. A complete list of covered bone marrow transplants may be obtained from any Kaiser Foundation Health Plan office. Services in the doctor's office relating to covered bone marrow transplants are provided at \$10 per visit. Experimental or investigational bone marrow transplants are NOT covered.

Immunosuppressive Drugs

Prescribed post surgical immunosuppressive drugs required after a covered transplant are provided at no charge when obtained at Plan pharmacies.

Terms and Conditions Relating to Covered Transplants

Covered transplants are provided only if they meet the following terms and conditions:

The Permanente Medical Group has developed certain medical criteria which you must meet before receiving services.

- The Plan covers care only at approved transplant or hemodialysis facilities. The Medical Group must provide a written referral for care from a facility not on the approved list.
- If you do not satisfy the medical criteria for the transplant service involved, only services provided before that determination are covered.
- Neither Kaiser Foundation Health Plan nor the Medical Group undertake to furnish a bone marrow donor or a donor organ, assure the availability of a donor or donor organ, or assure the availability or capacity of referral facilities approved by the Medical Group.
- Except for medically necessary ambulance service, neither transportation nor living expenses are covered for any person, including the patient.

HOME CARE AND HOSPICE SERVICES

Physician House Calls

Physician house calls will be provided within the service area when prescribed by a Plan physician. A house call is prescribed only when a Plan physician determines that necessary care can best be provided in the home.

Physician house calls are provided at a charge of \$10 for each family member treated.

Home Health Services

The following services are provided without charge in the service area when prescribed or directed by a Plan physician:

- *Members without Medicare benefits*
Skilled nursing services on part-time, intermittent basis.
- *Members with Medicare benefits*
Home health services covered under Medicare.
- *All members*
Ostomy supplies; IV fluids and medications, including additives and nutrients; and IV equipment and infusion pumps.

Hospice Services

Hospice care will be provided if you or a covered dependent have been diagnosed as having a terminal illness with a life expectancy of six months or less, and have chosen hospice care instead of the traditional services covered by the Plan.

The following services are covered when ordered by a Plan physician and the hospice care team:

- Nursing care.
- Physical, inhalation or occupational therapy, or therapy for speech language pathology.
- Medical social services.
- Home health aide and homemaker services.
- Medical supplies.
- Drugs and appliances.
- Physician services.
- Short-term inpatient care, including respite care and care for pain control and symptom management.
- Counseling and bereavement services and services of volunteers.

Note: *Members who elect hospice care are not entitled to any other benefits under this service agreement or under Medicare for the terminal illness while the hospice election is in effect. A member may revoke a hospice election at any time.*

EMERGENCY SERVICES

Emergency Services Received at Kaiser Permanente

The Plan covers emergency care received at Kaiser Permanente medical centers. This includes all Plan benefits as described in this section.

Emergency Services Received From Non- Plan Providers

- **Coverage Within the Service Area**

If you receive emergency care at a non-Plan facility within the service area, those services will be covered if transportation to a Plan health facility would have caused a delay likely to result in death, serious disability or significant jeopardy to your condition. Kaiser Foundation Health Plan will reimburse you for emergency services only if the charges are reasonable and the services meet the **Conditions of Coverage** listed later in this section

- **Coverage Outside the Service Area**

The Plan will pay for emergency services if you become ill or are injured while outside the service area. Kaiser Foundation Health Plan will reimburse you for emergency services only if the charges are reasonable and the services meet the **Conditions of Coverage** listed later in this section.

- **Maternity care**

Unexpected or premature (more than 31 days before expected delivery date) delivery is covered. Term delivery is not covered unless a member was outside the service area because of circumstances beyond her control or because of extreme personal emergency.

Conditions of Coverage

The Plan will pay for only those emergency services required before your medical condition permits transfer or travel to the nearest Kaiser Permanente medical center for care. Continuing or follow-up care is not covered. Eligibility for reimbursement depends on an objective determination that an emergency existed and not solely on the advice of the non-Plan provider.

Note: At its own discretion, Kaiser Foundation Health Plan may pay for care at a non-Plan hospital rather than transfer the patient.

Reduction and Co-payment

The amount otherwise paid or payable for emergency services is reduced by the total of:

- all amounts payable under any medical insurance, health benefit program or government program except Medicaid; and
- amounts that you would be responsible for paying if you had received care from Plan physicians or health facilities.

If the other source of coverage has denied the claim in whole or in part, or has not made payment within a reasonable time after the completed claim was submitted, Kaiser Foundation Health Plan will pay covered charges after you submit:

- an executed assignment of the claim against the other source of coverage; and
- a Kaiser Foundation Health Plan claim (see *"How to File a Claim"*).

COVERAGE WITHIN ANOTHER KAISER REGION'S SERVICE AREA

If you are temporarily visiting other Kaiser Foundation Health Plan service areas, you may obtain medical and hospital services at facilities maintained in those areas. Benefits and supplemental charges may vary in other regions. The coverage you receive in those regions may not be identical to your Northern California coverage.

Transferring Residence

If you transfer residence to another region, you must promptly apply to a Kaiser Foundation Health Plan office in that region to transfer membership. The right to out-of-Plan emergency benefits or services in another region ends after you have lived in that region more than 90 days, unless you receive prior written authorization from Kaiser Foundation Health Plan.

PAYMENT INSTEAD OF SERVICE BENEFITS

On certain occasions, you may require covered services which are not available within The Permanente Medical Group. This may include referral services outside the service area. In such cases, payment is made instead of service benefits if:

- You require covered services which require skills not available within The Permanente Medical Group or at Plan facilities; and
- The Permanente Medical Group determines that it is in your best interest to obtain care from another source; and
- The Permanente Medical Group assumes, in writing, financial responsibility for payment instead of service benefits.

You must pay any supplemental charges appropriate to your coverage.

WHAT SERVICES ARE NOT COVERED?

Exclusions from Coverage

- Services a member receives from a non-Kaiser Permanente physician, hospital or other provider of care, except as described in this guide.
- Financial responsibility for conditions covered by Workers' Compensation or for which care or reimbursement is available from a government agency or program, other than Medicaid.
- Military service-connected conditions, as defined by the Veterans Administration, for which care is available from the Veterans Administration.
- Custodial, domiciliary, convalescent and intermediate care.
- Cosmetic services, except for services described in this section.
- Dental care and dental X-rays, including dental care following accidental injury to teeth, dental appliances, orthodontia, and dental services associated with surgery on the jawbone.
- Physical examinations required for obtaining or continuing employment, insurance or government licensing.
- Services to reverse voluntary, surgically-induced sterility.
- Services (other than artificial insemination) related to conception by artificial means, including, but not limited to, in vitro fertilization and ovum transplants; and the cost of donor semen.
- Experimental or investigational services.
- Any health care procedure not generally and customarily provided in the service area, unless it is generally accepted medical practice to refer patients outside the service area for such services.
- Blood (unless replaced in accord with designated Blood Bank rules or covered by Medicare).
- Artificial organs and their implantation.
- All services related to sex changes.
- All services related to routine, non-medically necessary foot care.

Limitations in Services

Kaiser Permanente Health Plan is not responsible for the following:

- Delay or failure to render service due to a major disaster or epidemic affecting facilities or personnel.
- Interruption of services due to war, riot or labor disputes not involving Plan organizations; non-emergency care may be postponed in the event of labor disputes involving Plan organizations.
- Conditions for which a member has refused recommended treatment for personal reasons, when Plan physicians believe no professionally acceptable alternative treatment exists.

Coverage for the following is limited to the benefits described in this manual:

- Physical, inhalation, speech, rehabilitation and occupational therapy.
- Treatment for alcohol or drug dependency.
- Mental health care.
- Durable medical equipment.
- Prosthetic devices and braces.
- Eye examinations and glasses.
- Hearing test and aids.

DEFINITIONS

Emergency Services – Necessary health services immediately required for unforeseen illness or injury. Kaiser determines what is an “emergency” in accord with generally accepted standards of medical practice.

Extended Care – Care for which a patient medically requires the care or supervision of a registered nurse 24 hours per day.

CONTACT

For answers on benefit questions, verification of coverage, new member assistance, ID card replacement and to request a copy of your Evidence of Coverage, please contact Member Services Call Center during the following business hours:

Monday to Friday – 7:00AM to 7:00PM
Saturday & Sunday – 7:00AM to 3:00PM

English, Tagalog, and Vietnamese – 800.464.4000
Spanish – 800.788.0616
Chinese dialects – 800.757.7585

You may also go to www.kp.org

Health Plan Waiver Credit

If you are covered by another health plan (such as through a spouse's employer or your spouse's coverage at USF) and you do not need health plan coverage through USF, you may enroll in the Health Plan Waiver program

. An additional \$40 will be added to your taxable income each month. If you lose your other health plan coverage during the year because of a change in family status or the termination of your other plan, you may enroll in a USF health plan within 31 days of your loss of coverage. You may be required to show evidence of loss of coverage.

Medical Flexible Spending Accounts (FSA) – The Lipman Company (TLC)

The University of San Francisco's medical flexible spending accounts and dependant care flexible spending accounts are administered by The Lipman Company (TLC).

What Is a FSA?

A medical flexible spending account (FSA) allows you to earn and spend money for eligible medical expenses free of Federal and State income taxes and Social Security taxes. You pay no taxes when you deposit the money or when you withdraw it. You will probably be spending some out-of-pocket dollars each year on medical expenses that are not reimbursed or covered by your health plan such as deductibles, glasses, or charges in excess of what your health or dental plan will pay. These medical expenses that are not covered by your health or dental plan but which meet the criteria for an income tax deduction may be reimbursed through a medical flexible spending account.

How Does A Flexible Spending Account Work?

To open a medical flexible spending account, you need to estimate what you anticipate your out-of-pocket medical expenses will be in the next calendar year (or to the end of the current year if you enroll upon eligible employment in mid-year). Based on your estimate, you will indicate how much you want deposited to your account from your paycheck each pay period. This deposit amount is withheld from your paycheck each pay period before federal, state, and social security taxes are calculated. The effect is to reduce your taxable income, thereby reducing your taxes. Whenever you incur an eligible medical expense, you submit a claim for reimbursement on claim forms to The Lipman Company. The reimbursement from your account is paid to you, not to the provider of service.

What Are The Disadvantages of A Flexible Spending Account?

It is very important that you estimate your expenses carefully, because amounts deposited to your account that are not used in the same calendar year or IRS extended year cannot be returned to you. Also, because you are reducing your social security contribution, there could be an effect on your future social security benefit. If you participate in the 403(b) voluntary tax deferred annuity plan, your tax deferral maximum calculation must be based on your salary amount after the reduction for your flexible spending account has been made. This could reduce the amount that you can contribute to the 403(b) plan. Although these reductions usually are not significant amounts, you need to be aware of them.

The University of San Francisco is responsible for the payment of health expense claims if the dollar amount you are committed to deposit to your FSA for the entire calendar year is at least equal to your claim amount. It does not matter that you may not have deposited that amount to your account at that time.

Who is Eligible?

You are eligible to enroll upon eligible employment for the remainder of that calendar year or annually for the following calendar year prior to December 15. New enrollment must be completed each year that you wish to participate in the program. Once you have made your decision to

participate, you cannot change your designation unless there is a change in your family status which requires the change (such as gain or loss of dependents).

How Do I File A Claim?

Claims are reported on voucher forms. Voucher forms are available from Human Resources or at www.lipman.com.

Claims may be mailed or faxed to The Lipman Company at:

The Lipman Company
3340 Walnut Avenue, #290
Fremont, CA 94538
Fax (510) 795-0858

How May I Receive More Information?

A separate portfolio of information is available in Human Resources, including a brochure of detailed information, questions and answers about the flexible spending accounts program, an enrollment form, and a change of family status form. If you have additional questions after reviewing the portfolio, your Benefits Representative in Human Resources will be able to provide assistance or you may call The Lipman Company directly at 1-800-533-0113.

Delta Dental Plan of California

The Delta Dental plan provides for payment of a percentage of dental costs for you and your family. The percentage of payment varies from 50% to 100% depending on the type of dental service provided and whether the patient has used the plan in the previous year. If you use a dentist who has signed an agreement with Delta (a Delta Participating Dentist), there may be a lower outstanding balance remaining to be paid by you.

The cost for the Delta Dental Plan is fully paid by the University of San Francisco. You are eligible to enroll upon employment. An enrollment form must be completed within 31 days of your date of hire.

How Do I Use The Plan?

It is to your advantage to select a dentist or orthodontist who is a Delta Participating Dentist, because the fees charged have been accepted in advance by Delta. You may choose to receive services from any licensed dentist, but a lower percentage of the dentist's fees may be covered if you select a dentist who is not a Delta Participating Dentist. Ask your dentist if he/she is a Delta Participating Dentist or call Delta at (415) 972- 8300 or 1-888-335-8227 to verify a dentist's participation.

NOTE: *Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society which is listed in the telephone directory.*

During your first appointment, it is very important to provide your dentist with the following information:

- Your employer is USF
- Your Delta group plan number is: 2406
- Your (the employee's) social security number
- Other dental coverage for you and/or our dependents.

Do I Need Pre-Service Review?

It is strongly recommended that whenever extensive services such as gold work, bridges, or other procedures of a complex nature are involved, or when services will cost more than \$100, that your dentist submit an Attending Dentist's Statement to Delta to obtain a predetermination of costs before proceeding with the proposed treatment. This allows Delta to advise you and your dentist ahead of time whether the proposed treatment is covered and, if so, how much Delta will pay and how much will be your responsibility.

How Do I File Delta Claims?

Most dentists in California are familiar with Delta Dental programs and have Delta Attending Dentist's Statements (Delta Form 105). If not, the dentist may contact:

Delta Dental Plan of California

P.O. Box 7736
San Francisco, CA 94120
(415) 972-8300
1-888-335-8227

Your dentist should submit the Attending Dentist's Statement for payment to the Delta San Francisco office.

If you or your dependents are covered under more than one group dental plan, the amount payable will be prorated in accordance with the rules specified in the Delta contract so that the total payments by the programs or policies will not be greater than the cost of covered services (coordination of benefits). Be sure to tell your dentist of all plans under which you have dental coverage so that you will receive all payments and services to which you are entitled.

How Is Payment Made?

Payment for services performed by a participating dentist will be made directly by Delta to the Dentist. Payment will be based on the applicable percentage of the lesser of the fee actually charged or the accepted usual, customary and reasonable fee on file with Delta. Payment for services performed by a non-participating dentist may be made to an eligible person and shall not be assignable. Payment to a California dentist who is not a participating dentist will be based on the applicable percentage of the lesser of the fee actually charged or the fee which satisfies the majority of Delta's participating dentists, except for orthodontic services, payment for which is based upon the Delta Orthodontic Table of Allowances.

Payment to a dentist outside of California who cooperates with Delta in the administration of the program will be based on the applicable percentage of the lesser of the fee actually charged or the customary fee for corresponding services for participating dentists in California. Contracts between Delta and its participating dentists provide that, in the event Delta fails to pay the dentist, you will not be liable to the dentist for any sums owed by Delta. In the event Delta fails to pay a non-participating dentist, you may be liable to the dentist for the full cost.

NOTE: *Delta may deny payment of an Attending Dentist's Statement for services submitted more than six months after the date the services were provided.*

If a claim is denied submission, you shall not be liable to such dentist for the amount which would have been payable by Delta (unless you failed to tell the dentist of your eligibility at the time of treatment). Delta may require, as a condition for payment for services, that reasonable evidence of the extent or character of services be submitted or that you be examined by a dental consultant retained by Delta in or near your community of residence.

What Is The Delta Claims Appeal And Complaint Procedure?

Delta will notify you if any services are denied, in whole or in part, stating the specific reason or reasons for the denial based on the pertinent provisions of the Program. A copy of the Attending Dentist's Statement will be sent to you with an explanation of your right to review and the procedure to follow. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to:

Delta Dental Plan of California
P.O. Box 7736
San Francisco, California 94120
Attn: Benefit Services Department

State the reason(s) you are requesting reevaluation of the denial and request any pertinent documents that you wish to review.

Delta shall make a full and fair review of your request for reevaluation and may require additional documents as it deems necessary or desirable in making such a review. Certain requests may be referred to one of Delta's regional consultants, to a peer review committee of the dental society in your area, or to the California Dental Association, and Delta agrees to be bound by the decision of

the respective review committee. Unless referral to a review committee is required or other unusual circumstances arise, you should receive a decision on your request for review, in writing, within 30 days, but not longer than 120 days after Delta receives your request.

Any inquiries or complaints other than those involving the denial of services should also be addressed in writing to the office identified above. Use a Delta Inquiry/Complaint form, obtainable from Delta's office identified in the above section or at www.deltadental.com. Or, if you prefer, you may make your inquiry or complaint by telephone or in person. All complaints will be reviewed according to the same procedure and within the same time limits as described above.

Any dispute which is not settled by these procedures is subject to arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association in San Francisco or Los Angeles. Any party to a dispute, including an eligible person, may initiate arbitration by written notice to the other party in the dispute. This notice must state the intention to arbitrate and describe the nature of the dispute, the amount involved (if any), and the remedy sought. Two copies of this notice must be filed with the American Arbitration Association Regional Office in San Francisco or Los Angeles, with the fee required by the Association.

What Are The Delta Plan Benefits?

The plan provides payment of a percentage of the covered fee up to a maximum payment of \$1,500 each calendar year for each enrolled participant.

Diagnostic and Preventative, Basic, Crowns, Jackets and Cast Restoration Benefits

- 70% in the 1st calendar year of eligibility.
- 80% in the 2nd calendar year of eligibility if patient used the plan in the previous year.
- 90% in the 3rd calendar year of eligibility if patient used the plan in the previous years.
- 100% in the 4th calendar year of eligibility if patient used the plan in the previous years.

If an enrolled person does not use the plan during a calendar year, the percentage of payment will not change. (Example: An enrolled person uses the plan during the 1st and 2nd years of eligibility but not in the 3rd year when the payment percentage would be 90%. When the enrolled person uses the plan in the 4th year the payment percentage will be 90%).

Types of services include:

- Oral examination (no more than two per calendar year, including examinations under previous Delta Dental coverage).
- X-rays (see limitations).
- Study models.
- Biopsy/tissue examination.
- Emergency palliative treatment.
- Specialist consultation.
- Prophylaxis (cleaning) fluoride treatment (no more than two per calendar year).
- Space maintainers.
- Extractions and certain other surgical procedures including pre and post-operative care.
- Amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of dental decay.
- Treatment of the tooth pulp.
- Treatment of gums and bones supporting the teeth.
- Crowns, jackets and cast restorations for the treatment of dental decay which cannot be restored with other filling materials.

Prosthodontic Benefits

- 50% – This includes procedures for construction or repair of fixed bridges, partial or complete dentures.

Orthodontic Benefits

- 50% – For eligible dependent children to a lifetime maximum of \$1,500 for each child. (This maximum is separate from the annual \$1,500 maximum for other covered benefits). This includes procedures involving the use of an active orthodontic appliance and post-treatment retentive appliances, for treatment of malalignment of teeth and / or jaws which significantly interferes with their function.

Dental Accident Benefits

- 100% – This applies to all services listed above, subject to all of the conditions, limitations and exclusions, for conditions caused directly by external, violent and accidental means, independent of all other causes.

What Limitations And Exclusions Apply?

Diagnostic and Preventative, Basic, Crowns, Jackets and Cast Restoration Benefits

Limitations:

- An oral examination is a covered service only when the dentist has an accepted fee on file with Delta for this procedure and shall not be provided more than twice in any calendar year while the patient is covered under any Delta program.
- Benefits under this program shall include only the first two prophylaxes (cleanings), or single procedures that include prophylaxes, or combination thereof, provided to a patient in any calendar year while covered under any Delta program. This includes periodontal procedures which include prophylaxes.
- Unless special need is shown, full mouth X-rays are provided only after three years have passed following any prior provision of full-mouth X-rays under any Delta program. Supplementary bite-wing (individual) X-rays are provided on request by your dentist, but not more than once every six months while the patient is covered under any Delta program.
- Crowns, jackets and cast restorations will be replaced only after five years have passed following any prior provision under any Delta program.
- If a patient selects a more expensive plan of treatment than is customarily provided or specialized techniques rather than standard procedures, Delta will pay the applicable percentage of the lesser fee and the patient will be responsible for the balance. Examples: the choice of a crown or a precision denture where a standard denture would suffice; or the choice of a gold crown where a crown of semi- precious material would restore the tooth.

Exclusions:

Services for injuries or conditions which are compensable under Workers' Compensation or Employer's Liability Laws, services which are provided by any federal or state government agency, or are provided without cost to the eligible person by any municipality, county or other political subdivision, except Medical benefits.

- Services with respect to congenital (hereditary) or developmental (following birth) malformations, or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel

hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth and related procedures. Such services include, but are not limited to, equilibration and periodontal splinting.
- Prosthodontic services or any single procedure started prior to the date you or your dependents become eligible for such services under this program.
- Prescribed drugs, premedication or analgesia.
- Experimental procedures.
- All hospital costs and any additional fees charge by the dentist for hospital treatment.
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues) or implants (materials implanted into or on bone or soft tissue) or the removal of implants except as provided under Limitations on Prosthodontic Benefits above.
- Diagnosis or treatment by any method for any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

Prosthodontic Benefits

Limitations:

- Prosthodontic appliances (including, but not limited to, fixed bridges and partial or complete dentures) will be replaced only after five years have passed following any prior provision of such appliances under any Delta program, unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance which was not provided under a Delta program will be made only if the appliance is unsatisfactory and cannot be made satisfactory.
- Delta will pay 50% of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture, up to a maximum fee allowance which is at least the fee which would satisfy the majority of Delta's participating dentists for a standard denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials). The maximum allowance is revised periodically as dental fees change. Any denture and / or related service for which a charge is made which exceeds this allowance is considered an optional service and the patient will be responsible for the balance of the fee in excess of the Delta payment.

Exclusions:

- Implants (materials implanted into or on bone or soft tissue) or the removal of implants are not covered. If implants are provided along with a covered prosthetic appliance, Delta will pay 50% of the cost of a standard complete or partial denture toward the cost of the implants and prosthetic appliances. If Delta makes an allowance toward the cost of such procedures, Delta will not pay for any replacement until after five years have passed.

Dental Accident Benefits

Benefits shall be limited to services provided to a covered person within 180 days following the day of accident, and the accident must have happened on or after the patient's eligibility date.

Orthodontic Benefits

Limitations:

Delta's obligation to make monthly or other periodic payments for an orthodontic treatment plan begun prior to the eligibility date of the patient begins with the first payment due following the patient's eligibility date. The maximum amount payable by Delta for orthodontics (\$1,500) will apply fully to this and subsequent payments. Delta's obligation to make monthly or other periodic payments for an orthodontic treatment plan shall cease on the payment due date next following the termination of treatment for any reason prior to completion of the case or termination of coverage, whichever occurs first.

Exclusions:

- X-rays and extractions incident to orthodontics are not covered as orthodontic benefits, but may be covered under diagnostic and preventative or basic benefits.
- Orthodontic services (treatment of malalignment of teeth and/or jaws), except those services provided to eligible children as described.
- Charges for cost of replacement and/or repairs of an orthodontic appliance furnished in whole or in part under this program.

Vision Care – Vision Service Plan (VSP)

Vision Services plan (VSP) is a voluntary employer subsidized vision plan. USF subsidizes the rates at approximately 50% for employee and family coverage. Benefits include a comprehensive annual vision exam, and lenses and frames every two years at participating VSP provider.

WHAT ARE THE COSTS OF THE PLAN?

Costs depend on coverage: single, 2 party, or 3 party. Premiums are paid by payroll deduction on a pre-tax basis. Please call Human Resources for a summary plan description for current rates or see www.vsp.com.

WHAT ARE PLAN BENEFITS?

A comprehensive vision exam is provided annually. Lenses (single vision, lined bifocal and lined trifocal lenses) are covered in full every other calendar year. Frames are covered every other year (up to \$120). Or, when you choose contacts *instead* of glasses, you have a \$105 allowance that can be applied to the cost of your contacts and the fitting and evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.

OUT OF NETWORK BENEFITS

If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call VSP first 1-800-877-7195.

Out-of-Network Reimbursement Amounts:

Exam	up to \$45.00
Lenses:	
Single Vision	up to \$45.00
Lined Bifocal	up to \$65.00
Lined Trifocal	up to \$85.00
Frame	up to \$47.00
Contacts	up to \$105.00

HOW MAY I RECEIVE MORE INFORMATION?

To obtain more information call Human Resources for a summary plan description or see www.vsp.com.