



Modified for Samuel Merritt College PPOSM Student Health Plan Model without Student Health Center (Prudent Buyer **200/10/80/60**)

In addition to dollar and percentage copays, insured persons (students & dependents) are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Insured persons are also responsible for all costs over the plan maximums.

Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:
PPO Providers—PPO negotiated rates. Insured persons 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, insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Benefit year deductible for all providers	\$200/insured person; maximum of three separate deductibles/family
Deductible for non-PPO hospital or residential treatment center	\$500/admission (<i>waived for emergency admission</i>)
Deductible for non-PPO hospital, residential treatment center or ambulatory surgical center if services not preauthorized	\$500/admission (<i>waived for emergency admission</i>)
Deductible for emergency room services	\$50/visit (<i>waived if admitted directly from ER</i>)

Annual Out-of-Pocket Maximums

For all providers **\$2,000/insured person/year**

The following do not apply to out-of-pocket maximums: deductibles listed above; dollar copays; percentage copays for mental or nervous disorders & substance abuse; non-covered expense. After an insured person reaches the out-of-pocket maximum, the insured person no longer pays percentage copays for the remainder of the year. However, insured person 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.

Benefit Year Maximum

- Domestic Students & dependents **\$250,000/insured person/year**
- International Students & dependents **\$250,000/illness or injury/year**

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Hospital Medical Services (<i>preauthorization required for inpatient services; waived for emergency admissions</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	20%	40% ¹
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	20%	40% ¹
Ambulatory Surgical Centers (<i>preauthorization required; waived for emergency admissions</i>)		
➤ Outpatient surgery, services & supplies	20%	40% (<i>benefit limited to \$350/day</i>)
Skilled Nursing Facility (<i>preauthorization required</i>)		
➤ Semi-private room, services & supplies (<i>medical conditions & severe mental disorders limited to 100 days/benefit year; treatment of substance abuse limited to 30 days/benefit year</i>)	20%	40%
Hospice Care		
➤ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services		20% ²
Home Health Care (<i>preauthorization required</i>)		
➤ Services & supplies from a home health agency (<i>limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care</i>)	20%	40%

¹For California facilities, a discount applies if the facility has a contract with us 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 insured persons.

²These providers are not represented in the PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Home Infusion Therapy (<i>preauthorization required</i>)	20%	40%
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services		(benefit limited to \$600/day)
Physician Medical Services		
➤ Office & home visits	\$10/visit ¹ (deductible waived)	40%
➤ Hospital & skilled nursing facility visits	20%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	20%	40%
Diagnostic X-ray & Lab	20%	40%
Well Baby & Well-Child Care for Dependent Children		
➤ Routine physical examinations (<i>birth through age six</i>)	\$10/exam (deductible waived)	40% (benefit limited to \$20/exam)
➤ Immunizations (<i>birth through age six</i>)	No copay (deductible waived)	40% (benefit limited to \$12/immunization)
Physical Exams for Insured Persons Ages Seven & Older		
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam (limited to \$250/benefit year)	\$10/exam (deductible waived)	Not covered
Adult Preventive Services (<i>including mammograms, Pap smears, & prostate cancer screenings</i>)	20% (deductible waived)	40% (deductible waived)

¹The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services <i>(limited to 24 visits/benefit year; additional visits may be authorized)</i>	20%	40% <i>(benefit limited to \$25/visit)</i>
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	20%	40%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to \$30/visit & 12 visits/benefit year)</i>	20% ¹	40% ¹
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care <i>(services cover insured student, spouse & dependent daughters)</i>		
➤ Physician office visits	\$10/visit ² <i>(deductible waived)</i>	40%
➤ Prescription drug for elective abortion <i>(mifepristone)</i>	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion <i>(newborn routine nursery care covered when natural mother is insured student or insured spouse)</i>		
➤ Inpatient physician services	20%	40%
➤ Hospital & ancillary services	20%	40% ³

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

² The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

³ For California facilities, a discount applies if the facility has a contract with us 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 insured persons.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
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		20%
➤ Physician office visits (<i>including specialists and consultants</i>)		\$10/visit ¹ (<i>deductible waived</i>)
➤ 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>)
Bariatric Surgery (<i>preauthorization required; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE]</i>)		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		20%
➤ Physician office visits (<i>including specialists and consultants</i>)		\$10/visit ¹ (<i>deductible waived</i>)
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric COE (<i>member's transportation to & from COE limited to \$130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to \$130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & \$100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & \$100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to \$25/day/person for 4 days/trip</i>)		No copay (<i>deductible waived</i>)
MedCall[®]		
➤ A 24-hour service that connects insured persons to a nurse or audio library with a toll-free call; the number is printed on the insured person's ID card		No copay (<i>deductible waived</i>)
Diabetes Education Programs (<i>requires physician supervision</i>)		
➤ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	\$10/visit (<i>deductible waived</i>)	40%
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 (<i>limited to \$2,000/benefit year except for prostheses following a mastectomy or prosthetic devices following a laryngectomy</i>)	20%	40%
Durable Medical Equipment		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoes & inserts for insured persons with diabetes (<i>limited to \$5,000/benefit year</i>)	20%	40%

¹The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
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>)	20%	20%
➤ Inpatient hospital services & supplies	20%	20% first 48 hours; 40% ² after 48 hours (<i>unless insured person can't be moved safely</i>)
➤ Physician services	20%	20%
Mental or Nervous Disorders		
➤ Facility-based care (<i>preauthorization required; waived for emergency admissions; limited to \$500/day & 30 days/benefit year</i>)	20% ³	40% ^{2, 3}
➤ Inpatient or outpatient physician visits for psychotherapy & psychological testing (<i>limited to \$40/visit & 30 days/benefit year</i>)	20% ³	40% ³
Substance Abuse		
➤ Facility-based care (<i>preauthorization required; waived for emergency admissions; limited to \$500/day & 30 days/benefit year; the 30 days/calendar year limit does not apply to inpatient detoxification</i>)	20%	40% ²
➤ Inpatient or outpatient physician visits (<i>limited to \$40/visit & 50 visits/benefit year</i>)	20%	40%

¹These providers are not represented in the PPO network.

²For California facilities, a discount applies if the facility has a contract with us 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 insured persons.

³These limitations, 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 Participating behavioral health provider. Please see the Certificate for complete information.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
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Medical Evacuation Benefit for International Students

(expenses for transporting insured person back to home country for medical care & treatment limited to \$10,000; see Certificate for specific details)

No copay
(deductible waived)

Exclusions applicable to Medical Evacuation—

No payment will be made for expenses incurred for or in connection with any of the items below:

- **Mild conditions.** Services for medical evacuation when insured person has mild lesions, simple injuries such as sprains, simple fractures, or mild illness, which can be treated in the United States, or, if insured person is a United States student outside the United States, in the country where studying, which does not prevent insured person from continuing to participate in the Exchange Visitor Program for which insured person came to the United States for.
- **Not covered.** Services received before insured person’s effective date, services not specifically stated, such as care or treatment of an illness or injury.
- **Not needed.** Services for medical evacuation when physician does not certify, in writing, that insured person needs further medical care or treatment for an illness or accident that commenced or occurred, respectively, in the United States or, or, if insured person is a United States student outside the United States, in the country where studying.
- **For Foreign Nationals in the Exchange Visitor Program – Illness and Injury Outside the United States.** Services furnished and billed by a provider, unless such services or supplies are furnished in connection with an illness that commenced, or injury that occurred, while insured person was in the United States.
- **Traveling Companions.** The cost of airfare for a family member or traveling companion accompanying the insured person.

Repatriation Benefit for International Students

(in the event of insured person’s death, expenses for preparing & transporting the insured person’s bodily remains back to home country limited to \$7,500; see Certificate for specific details.)

No copay
(deductible waived)

Exclusions applicable to Repatriation Benefit—

No payment will be made for expenses incurred for or in connection with any of the items below:

- **Not covered.** Services received before insured person’s effective date
- **Death Outside the United States.** Services furnished to prepare and transport the insured person’s remains to country of legal residence if death occurred outside the United States..

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

PPO Student Health Plan—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. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

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 insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

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

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

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

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

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

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

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

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

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

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

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

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

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

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

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

Scalp hair prostheses. Scalp hair prostheses, including wigs or any for of hair replacement.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered, except as specified as covered in the Certificate.

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, except as specified as covered in the Certificate.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sports-Related Conditions. Expenses incurred for treatment of sport-related accidents resulting from interscholastic, intercollegiate, club or professional sports.

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) insured person'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 insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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

Excess Coverage – BC Life & Health Insurance Company will reduce the amount payable under this plan if expenses are covered under any other plan. We will determine the amount of benefits provided by other plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from other plans includes any amount to which the insured person is entitled, whether or not a claim is made for the benefits. The coverage under this policy is secondary coverage to all other policies.

*The Power of Blue.*SM

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