blue of california

Summary of Benefits

University of California
Effective January 1, 2026
PPO Plan

UC Care Plan

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: **UC Select Tier 1 and Blue Shield PPO Tier 2 Networks**

UC Care is a PPO Plan created just for UC. You can get care from UC physicians and medical centers as well as the Blue Shield PPO Tier 2 network of Providers. You also have coverage for services provided by Out-of-Network Providers. UC Select Tier 1 is focused on primary care, some specialty care, and hospitals. Therefore, not all services and provider types will be available in the UC Select Tier 1 Network. You can find providers in these networks at ucal.us/facultystaffppo or blueshieldca.com.

Calendar Year medical and pharmacy Deductibles (CYD)[2,9]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a UC Select Tier 1 Provider	When using a Blue Shield PPO Tier 2 Provider[3]	When using an Out-of-Network Provider[4]
Calendar Year medical and pharmacy Deductible	*Individual coverage*	*$0*	*$500*	*$750*
	Family coverage	*$0: Family*	*$1,000: Family*	*$1,750: Family*

Calendar Year medical and pharmacy Out-of-Pocket Maximum[5,9]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a UC Select Tier 1 Provider	When using a Blue Shield PPO Tier 2 Provider[3]	When using an Out-of-Network Provider[4]
Individual coverage	$6,100	$7,600	$9,600
Family coverage	$9,700: Family	$14,200: Family	$20,200: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount the Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
Preventive Health Services[7]						
Preventive Health Services	$0		$0		50%	✔
Physician services						
Primary care office visit	$30/visit		30%	✔	50%	✔
Specialist care office visit	$30/visit		30%	✔	50%	✔
Physician home visit	$30/visit		30%	✔	50%	✔
Other professional services						
Other practitioner office visit *Includes nurse practitioners and physician assistants.*	$30/visit		30%	✔	50%	✔
Acupuncture services *Combined with chiropractic services, up to 24 visits per Member, per Calendar Year.*	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	30%	✔
Chiropractic services *Combined with acupuncture services, up to 24 visits per Member, per Calendar Year.*	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Family planning						
• Counseling, consulting, and education	$0		$0		50%	✔
• Injectable contraceptive	$0		$0		50%	✔
• Diaphragm fitting	$0		$0		50%	✔
• Intrauterine device (IUD)	$0		$0		50%	✔

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
• Insertion and/or removal of intrauterine device (IUD)	$0		$0		50%	✔
• Implantable contraceptive	$0		$0		50%	✔
• Tubal ligation	$0		$0		50%	✔
• Vasectomy	$0		$0		50%	✔
Diagnosis and Treatment of the Cause of Infertility	20%		30%	✔	50%	✔
Infertility Services[8] Prior authorization is required through WINFertility Limited to 2 cycles per lifetime. Note: Once a member has completed Two (2) cycles of IVF-Egg Retrievals, the lifetime benefit maximum has been reached for all infertility related services, including Intrauterine Insemination (IUI) services. Note: Coinsurance for these services does not apply towards Calendar Year Out-of-Pocket Limit.						
• Natural artificial inseminations Without ovum [oocyte or ovarian tissue (egg)] stimulation.	50%		50%	✔	50%	✔
• Stimulated artificial inseminations. With ovum [oocyte or ovarian tissue (egg)] stimulation.	50%		50%	✔	50%	✔
• Gamete intrafallopian transfer (GIFT)	50%		50%	✔	50%	✔
• Zygote intrafallopian transfer (ZIFT)	50%		50%	✔	50%	✔

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	**CYD[2] applies**	**When using a Blue Shield PPO Tier 2 Provider[3]**	**CYD[2] applies**	**When using a Out-of-Network Provider[4]**	**CYD[2] applies**
• In-vitro fertilization (IVF)	50%		50%	✔	50%	✔
• Intracytoplasmic sperm injection (ICSI)	50%		50%	✔	50%	✔
• Cryopreservation of sperm, oocytes, embryos limited to one retrieval and one year of storage per lifetime.	50%		50%	✔	50%	✔
Pregnancy and maternity care						
Physician office visits: prenatal and postnatal	$30/visit (initial visit only)		30%	✔	50%	✔
Physician services for pregnancy termination	$0		$0		$0	
Emergency Services						
Emergency room services	$300/visit		$300/visit		$300/visit	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Blue Shield PPO Provider payment under Inpatient facility services/ Hospital services and stay.						
Emergency room Physician services	$0		$0		$0	

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	**CYD[2] applies**	**When using a Blue Shield PPO Tier 2 Provider[3]**	**CYD[2] applies**	**When using a Out-of-Network Provider[4]**	**CYD[2] applies**
Urgent care center services	$30/visit		$30/visit		50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	Services covered under Blue Shield PPO Tier 2 Provider		$200/transport		$200/transport	
Outpatient Facility services						
Ambulatory Surgery Center	$100/surgery		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Outpatient Department of a Hospital: surgery	$100/surgery		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Inpatient facility services						
Hospital services and stay	$250/admission		30%	✔	50% Subject to a Benefit maximum of $300/day	✔

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	**CYD[2] applies**	**When using a Blue Shield PPO Tier 2 Provider[3]**	**CYD[2] applies**	**When using a Out-of-Network Provider[4]**	**CYD[2] applies**
Transplant services *This payment is for all covered transplants except tissue and kidney and must be prior authorized and provided by a UC Select Tier 1provider or approved BCBS COE. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*						
• Special transplant facility inpatient services	$250/admission		30%	✔	Not covered	
• Physician inpatient services	$0		30%	✔	Not covered	
Bariatric surgery services *Bariatric services must be prior authorized and provided by a UC Select Tier 1 provider or BCBS COE.*						
Inpatient facility services	$250/admission		30%	✔	Not covered	
Outpatient Facility services	$100/surgery		30%	✔	Not covered	
Physician services	$0		30%	✔	Not covered	

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
Diagnostic x-ray, imaging, pathology, and laboratory services						
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.						
Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.						
Laboratory and pathology services						
Includes diagnostic Papanicolaou (Pap) test.						
• Laboratory center	$30/visit		30%	✔	50%	✔
• Outpatient Department of a Hospital	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Basic imaging services						
Includes plain film X-rays, ultrasounds, and diagnostic mammography.						
• Outpatient radiology center	$30/visit		30%	✔	50%	✔

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*						
• Office location	$30/visit		30%	✔	50%	✔
• Outpatient Department of a Hospital	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*						
• Outpatient radiology center	$30/visit		30%	✔	50%	✔
• Outpatient Department of a Hospital	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*						
Office location	$30/visit		30%	✔	50%	✔

Benefits[6]			Your payment			
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
Outpatient Department of a Hospital	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Speech Therapy services						
Office location	$30/visit		30%	✔	50%	✔
Outpatient Department of a Hospital	$30/visit		30%	✔	50% Subject to a Benefit maximum of $175/day	✔
Durable medical equipment (DME)						
DME	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Breast pump	$0		$0		50%	✔
Prosthetic equipment and devices	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔

Benefits[6]		Your payment				
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Home infusion and home injectable therapy services						
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Hemophilia home infusion services *Includes blood factor products.*	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔

Benefits[6]		Your payment				
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*						
Freestanding SNF	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Hospital-based SNF	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50% Subject to a Benefit maximum of $300/day	✔
Hospice program services						
Pre-Hospice consultation	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Routine home care	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
24-hour continuous home care	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Short-term inpatient care for pain and symptom management	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔
Inpatient respite care	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	50%	✔

Benefits[6]	Your payment					
	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using a Out-of-Network Provider[4]	CYD[2] applies
Other services and supplies						
Diabetes care services						
• Devices, equipment, and supplies	20%		30%	✔	50%	✔
• Self-management training	$30/visit		30%	✔	50%	✔
• Medical nutrition therapy	$30/visit		30%	✔	50%	✔
Dialysis services	$30/visit		30%	✔	50%	✔
PKU product formulas and special food products	Services covered under Blue Shield PPO Tier 2 Provider		30%	✔	30%	✔
Allergy serum billed separately from an office visit	20%		30%	✔	50%	✔
Hearing aid services						
• Hearing aids and equipment *Up to $2,000 combined maximum per Member, per 36-month period.*	Services covered under Blue Shield PPO Tier 2 Provider		50%	✔	50%	✔
Travel immunizations and vaccinations	$0		$0		50%	✔

Mental Health and Substance Use Disorder Benefits

Your payment

	When using a UC Select Tier 1 Provider	CYD[2] applies	When using a Blue Shield PPO Tier 2 Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Outpatient services						
Physician Services	$0 first 3 visits when using any combination of UC Select Tier 1 Providers and/or Blue Shield PPO Tier 2 Providers, then $30/visit		$0 first 3 visits when using any combination of UC Select Tier 1 Providers and/or Blue Shield PPO Tier 2 Providers, then $30/visit		50%	✔
Outpatient Facility Services	$30/visit		$30/visit		50%	✔
Inpatient services						
Physician inpatient services	$0		$0		50%	✔
Hospital services	$250/admission		$250/admission		50%	✔
Residential Care	$250/admission		$250/admission		50%	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Alcohol and Substance Use services
- Sleep Studies
- Inpatient facility services
- Durable Medical Equipment
- Hospice program services
- Continuous Glucose Monitoring
- CAR-T services
- Alcohol and Substance Use services
- Orthopedic surgery (I.e. Shoulder, Spine, Knee)
- Hearing Aids

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical or pharmacy Deductible. Some Covered Services received from Blue Shield PPO Providers are paid by the Claims Administrator before you meet any Calendar Year medical or pharmacy Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a separate Blue Shield Tier 2 PPO Provider Deductible and Out-of-Network Provider Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using UC Select Tier 1 and Blue Shield PPO Tier 2 Providers:

UC Select Tier 1 Providers and Blue Shield PPO Tier 2 Providers have a contract to provide health care services to Members. When you receive Covered Services from a UC Select Tier 1 or Blue Shield PPO Tier 2 Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Out-of-Network Providers:

Out-of-Network Providers do not have a contract to provide health care services to Members. When you receive Covered Services from an Out-of-Network Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Deductible or Out-of-Pocket Maximum and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the Calendar Year medical and pharmacy Deductible also count towards the Calendar Year Out-of-Pocket Maximum. Infertility services do not accrue to your Calendar Year Out-of-Pocket Maximum.

This Plan has a combined UC Select Tier 1 Provider and Blue Shield Tier 2 PPO Provider OOPM and a separate Out-of-Network Provider OOPM.

Notes

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit by a UC Select Tier 1 Provider or Blue Shield PPO Tier 2 Provider. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit. You can learn more about Preventive Health Services at www.blueshieldca.com/content/dam/bsca/en/member/docs/Preventive-Health-Guidelines.pdf.

8 Infertility Services:

A "cycle" is defined by this Plan as ovarian stimulation with egg(s) retrieval. Members will have coverage for two (2) egg retrieval cycles with fertilization of eggs and subsequent embryo transfer for all embryos created from a covered cycle. Infertility services do not accrue to your Calendar Year Out-of-Pocket Maximum.

9 Outpatient Prescription Drug Coverage (Navitus):

Outpatient prescription drug coverage is administered by Navitus. For information on outpatient prescription drug coverage, contact Navitus custom service at 833-8374308.

Plans may be modified to ensure compliance with Federal requirements.

Pb091825;100725;100825