blue of california

Summary of Benefits

University of California
Effective January 1, 2026
PPO Savings Plan

HealthSavings+

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: **Blue Shield PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Blue Shield PPO Providers. You pay less for Covered Services when you use a Blue Shield PPO Provider than when you use an Out-of-Network Provider. You can find Blue Shield PPO Providers in this network 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 Blue Shield PPO Provider[3]	When using an Out-of-Network Provider[4]
Calendar Year medical and pharmacy Deductible	*Individual coverage*	$2,500	$4,000
	Family coverage	$5,000	$8,000

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 Blue Shield PPO Provider[3]	When using an Out-of-Network Provider[4]
Individual coverage	$6,700	$8,000
Family coverage	$13,400	$16,000

No Annual or Lifetime Dollar Limit

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

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

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Diagnosis and Treatment of the Cause of Infertility	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%	✔
• Stimulated artificial inseminations With ovum [oocyte or ovarian tissue (egg)] stimulation.	50%	✔	50%	✔
• Gamete intrafallopian transfer (GIFT)	50%	✔	50%	✔
• Zygote intrafallopian transfer (ZIFT)	50%	✔	50%	✔
• In-vitro fertilization (IVF)	50%	✔	50%	✔
• Intracytoplasmic sperm injection (ICSI)	50%	✔	50%	✔
• Cryopreservation of sperm, oocytes, embryos limited to one retrieval and one year of storage per lifetime.	50%	✔	50%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	30%	✔	50%	✔
Physician services for pregnancy termination	$0	✔	$0	✔
Emergency Services				
Emergency room services *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.*	30%	✔	30%	✔
Emergency room Physician services	30%	✔	30%	✔

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Urgent care center services	30%	✔	50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	30%	✔	30%	✔
Outpatient Facility services				
Ambulatory Surgery Center	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Outpatient Department of a Hospital: surgery	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Inpatient facility services				
Hospital services and stay	30%	✔	50% Subject to a Benefit maximum of $360/day	✔
Transplant services *This payment is for all covered transplants except tissue and kidney and must be prior authorized and provided by a UC provider 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	30%	✔	Not covered	
• Physician inpatient services	30%	✔	Not covered	
Bariatric surgery services, designated California counties *Bariatric services must be prior authorized and provided by a UC provider or BCBS COE.*				
Inpatient facility services	30%	✔	Not covered	
Outpatient Facility services	30%	✔	Not covered	
Physician services	30%	✔	Not covered	

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an 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%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	30%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/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%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Advanced imaging services				
Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.				
• Outpatient radiology center	30%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, and respiratory therapy.				
Office location	30%	✔	50%	✔
Outpatient Department of a Hospital	30%	✔	50%	✔
Speech Therapy services				
Office location	30%	✔	50%	✔
Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Durable medical equipment (DME)				
DME	30%	✔	50%	✔
Breast pump	$0		Not covered	
Glucose monitor	30%	✔	50%	✔
Peak Flow Meter	30%	✔	50%	✔
Prosthetic equipment and devices	30%	✔	50%	✔
Home health care services	30%	✔	Not covered	
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.				
Home infusion and home injectable therapy services				
Home infusion agency services	30%	✔	Not covered	
Includes home infusion drugs, medical supplies, and visits by a nurse.				

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Hemophilia home infusion services *Includes blood factor products.*	30%	✔	Not covered	
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	30%	✔	50%	✔
Hospital-based SNF	30%	✔	50% Subject to a Benefit maximum of $360/day	✔
Hospice program services				
Pre-Hospice consultation	30%	✔	Not covered	
Routine home care	30%	✔	Not covered	
24-hour continuous home care	30%	✔	Not covered	
Short-term inpatient care for pain and symptom management	30%	✔	Not covered	
Inpatient respite care	30%	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	30%	✔	50%	✔
• Self-management training	30%	✔	50%	✔
• Medical nutrition therapy	30%	✔	50%	✔
Dialysis services	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
PKU product formulas and special food products	30%	✔	30%	✔
Allergy serum billed separately from an office visit	30%	✔	50%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $2,000 combined maximum per Member, per 36-month period.*	50%	✔	50%	✔
Travel immunizations and vaccinations	30%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits

	Your payment: When using a Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Outpatient services				
Physician Services	30%	✔	50%	✔
Outpatient Facility Services	30%	✔	50%	✔
Inpatient services				
Physician inpatient services	30%	✔	50%	✔
Hospital services	30%	✔	50%	✔
Residential Care	30%	✔	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.

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 PPO Provider Deductible and Out-of-Network Provider Deductible. *For Family Coverage*. The Family Deductible must be met by you and your Family members collectively within a Calendar Year.

3 **Using Blue Shield PPO Providers:**

Blue Shield PPO Providers have a contract to provide health care services to Members. When you receive Covered Services from a Blue Shield PPO 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 separate Blue Shield PPO OOPM and Out-of-Network Provider OOPM.

For Family coverage. The Family OOPM must be met by you and your Family members collectively 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.

Notes

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 Blue Shield PPO 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.](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. Member's 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.

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