Your Group Plan

University of California

UC CARE IN-AREA PLAN
2002 AMENDMENT

Amendment to Evidence of Coverage

I. The Introductory Pages are amended as follows:

PAGE 2: The following paragraph is added at the end of the section:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at the toll free Member services number listed on your ID Card to ensure that you can obtain the health care services that you need.

II. The Plan Procedure Section is amended as shown below:

PAGE 4: Sub-Section A, **Tier 1** Benefits. # 1 *Selecting a Participating Primary Care Physician:*

The **Plan** uses a network of independent **Participating Providers**, comprised of **Physicians**, **Hospitals** and other **Health Professionals** and facilities throughout the **Service Area**. Certain **PCP** offices are affiliated with Medical Groups (i.e. integrated delivery systems, Independent Practice Associations and Physician-Hospital Organizations), and if you choose a **PCP** with this type of affiliation, you will generally be referred to **Specialists** and **Hospitals** within that **Medical Group**. Each **Primary Care Physician (PCP)** is associated with a **Participating Hospital.** You must use the **Hospital** with which your **Primary Care Physician** is associated except when it is **Medically Necessary** to receive services elsewhere or when obtaining certain Direct Access **Specialist** benefits as described in this **EOC.**

At the time of enrollment, you should select a **Participating Primary Care Physician** (**PCP)** from the **Plan's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **EOC**. The choice of a **PCP** is made solely by you. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. If you do not select a **PCP** within a reasonable time after being eligible for **Covered Benefits**, the **Plan** will designate a **PCP** for you and notify you of its selection. You can change the **PCP** selection. The **PCP** is not an agent or employee of the **Plan** and the **Plan's** selection of a **PCP** is merely a convenience for **Members** to their assure access to **Covered Benefits**. Until a **PCP** is selected, you will not receive benefits under Tier 1 except for coverage for **Medical Emergency** care or **Urgent Care** services received outside the **Plan's Service Area**.

PAGE 5: Subsection A, Tier 1 Benefits *# 5 Requesting a Standing Referral Under Tier 1*

If you have been diagnosed with (i) a **Life-Threatening** or **Seriously Debilitating Condition** or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request that a **Specialist** or **Specialty Care Center** assume responsibility for providing or coordinating your medical care, including primary and specialty care. You may make this request through your **PCP** or **Specialist**. You or your **Physician** will be sent a form to be completed and returned to the **Plan** for review. If the **Plan**, or your **PCP**, in consultation with a **Plan** medical director and **Specialist**, if any, determines that your care would most appropriately be coordinated by a **Specialist** or **Specialty Care Center**, your **PCP** will authorize a **Standing Referral** to such **Specialist** or **Specialty Care Center** for up to twelve (12) months. Such determination will be made within three (3) business days of the date that all appropriate medical records and other items of information necessary to make the determination are provided and, once a determination is made the **Referral** will be issued within four (4) business days.

Any authorized **Referral** shall be made pursuant to a treatment plan approved by the **Plan** in consultation with your **PCP** (if appropriate), the **Specialist** or **Specialty Care Center**, and you or your designee. The approved **Specialist** or **Specialty Care Center** will be permitted to treat you without further **Referral** from your **PCP** and may authorize such **Referrals**, procedures, tests and other **Medical Services** as your **PCP** would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. For the purposes of this coverage, a **Specialty Care Center** means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the **Life-Threatening or Seriously Debilitating Condition** for which it is accredited or designated.

You will receive **Standing Referrals** to an **Appropriately Qualified Specialist** within your **PCP's** affiliated Medical Group, if available, or to an **Appropriately Qualified Participating Specialist.** The **Plan** is not required to permit you to elect to have a non-participating **Specialist**, unless an **Appropriately Qualified Specialist** is not available within the **Plan's** network of **Participating Providers**. If your approved **Standing Referral** is to a nonparticipating **Provider**, services provided pursuant to the approved treatment plan will be provided at no extra cost to you beyond what you would otherwise pay for services received within the **Plan** network of **Participating Providers.** You may call Member Services at the toll-free number listed on your ID card for additional information regarding **Appropriately Qualified Participating Specialists.**

PAGE 6: Sub-Section A, **Tier 1** Benefits. # 7 *Facilities, second paragraph is amended as shown:*

A **Provider** directory listing **Health Care Professionals**, **Participating Hospitals**, laboratories, pharmacies, **Skilled Nursing Facilities**, home health agencies and other ancillary health care and subacute facilities will be distributed to **Members**. If another copy of the directory is needed, you may call the **Contract Holder** or Member Services at the toll free telephone number listed on your identification card. The list of **Participating Providers** is subject to change.

III. The Covered Benefits Section is amended as shown below:

PAGE 11: The following is inserted after the first paragraph:

ALL SERVICES ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS DESCRIBED IN THIS **EOC**.

PAGE 13: Sub-Section A.5.c. is amended as shown below:

c. routine gynecological examinations, including pap smears or other cervical cancer screening test approved by the federal Food and Drug Administration, and related laboratory services, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access **Specialist** Benefits section of this **EOC** for a description of the requirements for Direct Access.

PAGE 16: The following is inserted at the end of Sub-Section F **Inpatient Hospital Benefits**

Inpatient **Hospital** cardiac and pulmonary rehabilitation services are covered by **Participating Providers** (upon **Referral** issued by the **Member's PCP** and pre-authorization by **HMO**.

PAGES 19, 20: Sub-Section O Hospice Benefits is amended as shown below.

O. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when **Pre-Authorized** by the **Plan**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family member; inpatient care; counseling including bereavement counseling and emotional support; and other home health benefits listed above.

Nursing care services are covered on a continuous basis during periods of crisis as necessary to maintain an enrollee at home. Homemaker or home health aide services may be covered, but the care provided must be predominantly nursing care. A period of crisis is a period in which the **Member** requires continuous care to achieve palliation or management of acute medical symptoms. Hospitalization will be covered if skilled nursing care is required at a level that cannot be provided in the home.

Respite care will be provided only when necessary to relieve the family members or other persons caring for the enrollee. Coverage of respite care will be limited to an occasional basis and to no more than five consecutive days at a time.

Coverage is not provided for funeral arrangements, pastoral counseling, financial or legal counseling.

PAGE 23: Sub-Section W, Additional Benefits: a new section. *Clinical Cancer Trials* is added:

- **Clinical Cancer Trials, Phase I, II, II or IV:** As an exception to the exclusion of treatments determined to be **Experimental or Investigational**, routine health care services are covered for **Members** whose treating **Provider** determines that a clinical cancer trial has a meaningful potential to benefit the **Member** and recommends participation. The clinical trial must involve a drug that is exempt under federal regulations from a new drug application and approved by the National Institute of Health, the FDA, the US Department of Defense or the Veteran's Administration. Routine health care services include the provision of drugs, items, devices and services which would be **Covered Benefits** if provided other than in connection with an approved clinical trial program, including health care services which are:

  a. typically provided absent a clinical trial;

  b. required solely for the provision of the investigational drug, item, device, or service;

  c. required for the clinically appropriate monitoring of the investigational item or service; or;

  d. provided for the prevention or treatment of complications arising from the provision of the investigational drug, item device, or service;

  Routine health care services do not include:

  a. drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial;

  b. travel, housing, companion expenses, and other non clinical expenses that a **Member** may require as a result of the treatment being provided in the clinical trial;

  c. items or services provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;

  d. services that are not **Covered Benefits** under the plan, if provided other than as part of the clinical trial; and

  e. services customarily provided free of charge for participants in the clinical trial.

  The **Plan** may restrict coverage for clinical trials to **Participating Hospitals** and **Physicians** in California unless the protocol for the clinical trial is not provided for a California **Hospital** or by a California **Physician**.

  The copayments applied to services delivered in a clinical trial will be the same as those applied to the same services if not delivered in a clinical trial.

PAGES 23, 24: Sub-Section W, Additional Benefits, *Infertility Services* is deleted and replaced with the following:

· **Infertility** Services are not covered under Tiers 2 and 3.

Infertility Services. The following **Infertility** services are covered without a **Referral** when rendered by a **Participating Provider.**

1. Direct Access by female **Members** to **Participating** Gynecologists or **Infertility Specialists** for basic diagnosis and treatment **Infertility** services, including:

   a. initial evaluation, including history and physical, laboratory studies performed at the **Participating** laboratory designated by the **Plan** to your **PCP** or, if none has been designated to your **PCP**, at any **Participating** laboratory;

   b. evaluation of ovulatory function;

   c. ultrasound of ovaries at the **Participating** radiology facility designated by the **Plan** to your **PCP** or, if none has been designated to your **PCP,** at any **Participating** radiology facility;

   d. post-coital test;

   e. hysterosalpingogram;

   f. endometrial biopsy; and

   g. hysteroscopy.

2. Semen analysis for a male **Member** with a **Referral** from his **PCP.**

3. **Members** may be eligible to receive coverage for the following Comprehensive **Infertility** services through a **Participating Infertility Specialist** upon pre-authorization by the **Plan:**

   a. ovulation induction in the **Participating Infertility Specialist's** office, subject to a maximum of six (6) cycles per lifetime (where lifetime is defined to include services provided or administered by the **Plan** or any affiliated company of the **Plan**);

   b. artificial insemination (AID, AIH, IUI), subject to a maximum of six (6) cycles per lifetime (where lifetime is defined to include services provided or administered by the **Plan** or any affiliated company of the **Plan**; and

   c. **Infertility** surgery (diagnostic or therapeutic).]

To be eligible for the Comprehensive **Infertility** Services above, the **Member** must be covered under the **EOC** as a **Subscriber** or **Subscriber's** legal spouse; and

1. have a condition that is a demonstrated cause of **Infertility** as recognized by a **Participating** gynecologist or **Participating Infertility Specialist** and documented in the **Member's** medical records; or

2. be unable to conceive after a year or more of unprotected coitus or (twelve) 12 cycles of artificial insemination (for **Members** less than thirty-five (35) years of age) or six (6) months or more of unprotected coitus or 6 cycles of artificial insemination (for **Members** thirty-five (35) years of age or older).

IV. The Exclusions and Limitations Section is amended:

PAGES 26, 27: Exclusion # 25. is deleted and replaced with the following:

25. **Infertility** Services not explicitly covered, as provided in the Covered Benefits section of this **EOC**. This exclusion includes, but is not limited to:

   b. Services for couples in which on of the partners has had a previous sterilization procedure, with or without reversal;
   c. Services for females with FSH levels greater than 19mIU/ml on Day 3 of the menstrual cycle;
   d. The purchase of donor sperm and any charges for the storage of sperm;
   e. The purchase of donor eggs and any charges associated with the care of donor required for donor egg retrievals or transfers or gestational carriers;
   f. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, **Hospital**, ultrasounds, laboratory tests, etc.)
   g. Artificial Insemination for females without male partners attempting to become pregnant who have not had at least twelve (12) cycles of donor insemination (six (6) cycles for **Members** age thirty-five (35) or older) prior to enrolling in **HMO's Infertility** program;
   h. Any service provided by a non-participating **Provider** or, in the case of Comprehensive **Infertility** Services, without a prior **Referral** or claim authorization from **HMO's Infertility** program case management unit;
   i. Home ovulation prediction kits;
   j. Drugs related to the treatment of non-covered benefits or related to the treatment of **Infertility** that are not **Medically Necessary**;
   k. Injectable **Infertility** medications, including but not limited to menotropins, hCG, GnRH, agonists, and IVIG;
   l. Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI);
   m. Any charges associated with care required for ART (e.g., office, **Hospital**, ultrasounds, laboratory tests, etc.);
   n. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
   o. Any charges associated with a frozen embryo transfer, including but not limited to thawing charges;

p. Reversal of sterilization surgery; and
q. Any charges associated with obtaining sperm for any ART procedures.

PAGE 27: Exclusion #27 is amended as shown below:

27. Missed Appointment charges.

PAGE 29: Exclusions #29., #36., and #56. are deleted and replaced by the following exclusion:

56. Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the **Covered Benefits** section of this **EOC**.

V. The Coordination of Benefits Section is amended.

PAGES 39 - 41: A new item A is inserted:

A. The Primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

Item A is renumber as B.

A new Item C is inserted:

C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

Items B, C, D, E, , are renumbered D, E, F, G.

A new Item H is inserted:

If the preceding rules do not determine the primary plan, the **Allowable Expenses** shall be shared equally between the plans meeting the definition of plan under this section. In addition this **Plan** will not pay more than it would have paid if it had been primary.

PAGE 41: The second and third paragraphs of sub-section Payment of Benefits are deleted.

VI. The Third Party Liability and Right of Recovery Section is amended as shown below.

PAGES 42,43:

If the **Plan** provides health care benefits under this **EOC** to a **Member** for injuries or illness for which a third party is or may be responsible, then the **Plan** retains the right to repayment (a lien), to the extend permitted by law, for the value of all benefits provided by the **Plan** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. This right of recovery applies to any recoveries made by or on behalf of the **Member** from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any workers' compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a **Member** for injuries resulting from alleged negligence of a third party. In some cases, **Participating Providers** may also assert the **Plan's** lien. Some **Providers** also have lien rights that are independent of the **Plan's** rights stated in this section.

The **Member** ~~also~~ specifically acknowledges the **Plan's** right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the **Plan** has provided health care benefits for injuries or illness for which a third party is or may be responsible and the **Member** and/or the **Member's** representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By using any benefit under this **EOC**, the **Member** grants, to the extent permitted by law, an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the value of all benefits provided by the **Plan**.

The **Member** and the **Member's** representatives further agree to:

A. Notify the **Plan** promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the **Member** that may be the legal responsibility of a third party; and

B. Cooperate with the **Plan** and do whatever is necessary to secure the **Plan's** rights of reimbursement under this **EOC**; and

C. Give the **Plan** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent permitted by law of the value of all benefits associated with injuries or illness provided by the **Plan** for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, the portion of any and all amounts due the **Plan** as permitted by law as reimbursement for the value of all benefits associated with injuries or illness provided by the **Plan** for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by the **Plan** in writing; and

E. Do nothing to prejudice the **Plan's** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by the **Plan**.

VII. The General Provisions Section is amended as follows:

PAGE 45: Sub-Section F, Independent Contractor Relationship, #4, is deleted and replaced with the following:

4. The **Plan** cannot guarantee the continued participation of any **Provider** or facility with the **Plan**.

   a. In the event the **Plan** terminates its contract with a **PCP**, Medical Group or Individual Practice Association, the **Plan** shall provide notification to **Members** in the following manner:

      i. At least 30 days prior to the termination date the **Plan** will send written notification to **Members** who are currently enrolled in the **PCP's** office; or are receiving an **Active Course of Treatment** from other terminating **Providers**.

      ii. You must notify the **Plan** of your new choice of **PCP** prior to the date of your **PCP's** termination, or the **Plan** will assign a new **PCP** to you**.**

   b. In the event a **PCP**, Provider Group, or Independent Practice Associations terminates its contract with the **Plan**, or the **Plan** terminates a **PCP** contract without notice for endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the **Plan** will notify **Members** as soon as possible, but no later than within 30 days of the termination date. **Medically Necessary Services** rendered by a **PCP** or **Provider** shall continue to be **Covered Benefits** during the period between the date of termination of the contract and 5 business days after notification of the contract termination is mailed to **Members** at their last known address.

      Services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

   If you are undergoing an **Active Course of Treatment** when you receive a notice of **Provider** termination you may refer to the Plan Procedure section, "Requesting Continuity of Care", for information about how to continue treatment with a terminated **Provider** for a limited time.

PAGE 45: Sub-Section I, *Confidentiality* is amended as shown below:

Confidentiality. Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by the **Plan** without your consent when necessary for your care or treatment, the operation of the **Plan**, the administration of this **EOC**, or other activities, as permitted by applicable law. For other purposes, information may be disclosed only with your consent. You can obtain an up-to-date copy of the **Plan's** Notice of Information Practices by calling Member Services toll-free telephone number listed on your Identification Card.

PAGE 47: Sub-Section "T", is added.

From time to time the **Plan** may offer or provide **Members** access to discounts on health care related goods or services. While the **Plan** has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the **Members** for the provision of such goods and/or services. The **Plan** is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the **Plan** is not liable to the **Members** for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

VIII The Definitions Section is amended as shown below:

PAGE 47: The definition of **Allowable Expense** is deleted and replaced with the following:

- **Allowable Expense.** Any **Medically Necessary** health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made. A health care service or expense including **Deductibles**, **Coinsurance** or **Copayments** that is covered in full or in part by any of the plans covering the **Member**, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an **Allowable Expense**. The following are examples of expenses or services that are not an **Allowable Expense**:

  1. If a **Member** is confined in a private **Hospital** room, the difference between the cost of a semi-private room in the **Hospital** and the private room, (unless the patient's stay in the private **Hospital** room is **Medically Necessary** in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private **Hospital** rooms) is not an **Allowable Expense**.
  2. If a **Member** is covered by 2 or more plans that compute their benefit payments on the basis of the **Reasonable Charge**, any amount in excess of the lowest of the **Reasonable Charges** for a specified benefit is not an **Allowable Expense**.
  3. If a **Member** is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fees for a specified benefit is not an **Allowable Expense**.
  4. If a **Member** is covered by one plan that calculates its benefits or services on the basis of **Reasonable Charges** and another plan that provides its benefits or services on the basis of negotiated fees, the lowest payment arrangement shall be the **Allowable Expense** for all plans.
  5. The amount a benefit is reduced by the primary plan because a **Member** does not comply with the plan provisions is not an **Allowable Expense**. Examples of these provisions are second surgical opinions, pre-authorization requirements, and **Participating Provider** arrangements.

PAGE 51: The definition of **Life Threatening or Seriously Debilitating Condition** is amended as shown below:

- **Life-Threatening Or Seriously Debilitating Condition.** A disease or condition (including the diagnosis of HIV OR AIDS):

  1. where the likelihood of death is high unless the course of the disease is interrupted;
  2. with potentially fatal outcome, where the end point of clinical intervention is survival; or
  3. that causes major irreversible morbidity.

PAGE 52: The definition of **Participating Infertility Specialist** is added:

- **Participating Infertility Specialist.** A **Specialist** who has entered into a contractual agreement with **HMO** for the provision of **Infertility** services to **Members**.

PAGE **52**: The definition of **Reasonable Charge** is deleted and replaced with the following:

- **Reasonable Charge.** The usual, customary, and reasonable charge for a **Covered Benefit.** Only that part of a charge which is usual, customary and reasonable is covered. The usual, customary and reasonable charge for a service or supply is the lowest of:

  1. the **Provider's** usual charge for furnishing it, and
  2. the charge **HMO** determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
  3. the charge **HMO** determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, **HMO** may have an agreement, either directly or indirectly through a third party, with a **Provider** which sets the rate that **HMO** will pay for a service or supply. In these instances, in spite of the methodology described above, the usual customary and reasonable charge is the rate established in such agreement.

In determining the usual, customary and reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of **Providers** in the area, **HMO** may take into account factors, such as :

1. the complexity;
2. the degree of skill needed;
3. the type of specialty of the **Provider**;
4. the range of services or supplies provided by a facility; and
5. the prevailing charge in other areas.

IX. The Pharmacy Rider is amended as follows:

PAGES 57- 58: Subsection G is amended as shown:

G. **Copayments.**

You are responsible for the **Copayments** specified in this rider. The **Copayment,** if any, is payable directly to the **Participating Retail or Mail Order Pharmacy** for each prescription at the time the prescription is dispensed. If you obtain more than a thirty (30) day supply of prescription drugs or medicines at the **Participating Mail Order Pharmacy**, not to exceed a ninety (90) day supply, one **Copayment** is payable for each supply dispensed**.** The **Copayment** is not subject to the annual maximum out-of-pocket limit set forth in the Schedule of Benefits for the medical plan, if any.

- The **Member** is responsible for a **Copayment** in the amount of **$15.00** per prescription or refill for a **Generic Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$25.00** per prescription or refill for a **Brand Name Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$40.00** per prescription or refill for a **Non-Formulary Prescription Drug**.
- **For Prescriptions filled at Participating Mail Order Pharmacies:**
- The **Member** is responsible for a **Copayment** in the amount of **$30.00** per prescription or refill for a **Generic Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$50.00** per prescription or refill for a **Brand Name Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$80.00** per prescription or refill for a **Non-Formulary Prescription Drug**.

X. The Schedule of Benefits is amended as follows:

PAGES: 61-66: The Schedule of Benefits, including the Prescription Drug Schedule of Benefits, is replaced with the following:

AETNA U.S. HEALTHCARE OF CALIFORNIA INC.
BENEFITS UNDER THE USACCESS PROGRAM

SCHEDULE OF BENEFITS

The USAccess plan provides coverage for **Referred** and **Non-Referred Benefits** received from **Participating Providers** and **Non-Participating Providers**.

Covered Benefits, Medical Necessity, precertification, concurrent review, retrospective record review and all other terms and conditions of your health plan are determined at the sole discretion of Aetna U.S. Healthcare (or its designee). This means that some services recommended by your health professional may not be deemed covered benefits as determined by Aetna U.S. Healthcare.

OUTPATIENT BENEFITS

Benefit	Tier 1 Referred Care	Tier 2 Participating Provider Self-Referral*	Tier 3 Non-Participating Provider Self Referred*
Deductible Amount: **The family Deductible is a cumulative Deductible for all family Members.**	**None**	**None**	**$500 per Member per calendar year. $1,500 per family per calendar year.**
Maximum Out-of-Pocket Limit Includes the Deductible Amount **Out-of-Pocket expenses paid under Tier 2 and Tier 3 combine to meet the Out-of Pocket maximums.**	**$1,500 per Member or $4,500 per family per calendar year.**	**$3,000 per Member or $9,000 per family per calendar year.**	**$12,000 per Member or $36,000 per family per calendar year.**
In addition to the charges listed on pg. 10 of the EOC, the following expenses do not apply to the out-of-pocket Limit: **Copayments for prescription drugs, in-area chiropractic and acupuncture services, behavioral health program services and amounts used to satisfy the hospital emergency room deductible under the UC Care Tiers 2 and 3 and Out-of-Area benefits.**			
Maximum Benefit for all Services and Supplies: **Combined Tier 2 and Tier 3 lifetime maximum benefit.**	**None**	**$2,000,000 per Member per lifetime.**	**$2,000,000 per Member per lifetime.**
Hospice **inpatient and outpatient**	**None**	**None**	**$10,000 per lifetime.**
Pre-Authorization Penalty services require Precertification or benefits will be reduced.	**None**	**None**	**50% per service or supply for all related services and supplies.**

***Certain services require Pre-Authorization or benefits will be reduced.**
Please refer to the EOC for services requiring Pre-Authorization.

Benefit	Tier 1 Referred Care Member Responsibility	Tier 2 Participating Provider Self-Referral* Member Responsibility	Tier 3 Non-Participating Provider Self Referred* Member Responsibility
Primary Care Physician Office Visit			
During Office Hours	**$20 copay** **(No copay for children under age 6.)**	**$50 copay**	**40% after Deductible**
Well Baby and Child Care	**$20 copay**	**$50 copay**	**40% after Deductible**
To age 19	**(No copay for children under age 6.)**	**(No copay for children under age 2.)**	**(0% for children under age 2.)**
Adult Physical Exam	**$20 copay**	**Not covered**	**Not covered**
Immunizations	**$20 copay** **(No copay for children under age 6.)**	**$50 copay to age 19** **(No copay for children under age 2.)**	**40% after Deductible to age 19** **(0% for children under age 2.)**
Specialist Physician Office Visit	**$20 copay** **(No copay for children under age 6.)**	**$50 copay**	**40% after Deductible**
Outpatient Rehabilitation Benefits: Physical, Speech and Occupational Therapy	**$20 copay**	**$50 copay** **Pre-certification required**	**40% after Deductible** **Pre-certification required**
First Maternity Visit	**$20 copay**	**$50 copay**	**40% after Deductible**
Subsequent Maternity Visits	**$0 copay**	**$0 copay**	**40% after Deductible**
Routine Gynecological Exam(s) 1 visit per 365 days	**$20 copay**	**$50 copay**	**40% after Deductible**
Hospital Outpatient Department Visit (Chemotherapy, Radiation)	**$0 copay**	**$50 copay**	**40% after Deductible**
Diagnostic Testing			
at physician's office	**$0 copay**	**$0 copay**	**40% after Deductible**
at facility	**$0 copay**	**$50 copay**	**40% after Deductible**
Outpatient Emergency Services **Hospital Emergency Room or Outpatient Department. Waived if admitted. Inpatient copay applies instead.**	**$75 copay**	**$75 copay**	**$75 copay**
Ambulance	**$0 copay**	**$0 copay**	**0%**
Urgent Care Facility	**$75 copay**	**$75 copay**	**$75 copay**

***Certain services require Pre-Authorization or benefits will be reduced.**
Please refer to the EOC for services requiring Pre-Authorization.

Benefit	Tier 1 Referred Care Member Responsibility	Tier 2 Participating Provider Self-Referral* Member Responsibility	Tier 3 Non-Participating Provider Self Referred* Member Responsibility
Outpatient Mental Health Serious Mental Illness is covered the same as any other illness or injury.	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Outpatient Substance Abuse Visits:	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Outpatient Surgery	**$0 copay**	**$250 copay**	**40% after Deductible**
Outpatient Home Health Visits: **Limited to 1 visit per day; 1 visit equals a period of up to 4 hours or less and equals a visit by a home health agency.** **Tier 2 and 3 combined maximum of 100 visits per calendar year.**	**$0 copay**	**$0 copay**	**40% after Deductible**
Outpatient Hospice Visits	**$0 copay**	**$0 copay**	**40% after Deductible** **$10,000 lifetime maximum combined inpatient and outpatient.**
Private Duty Nursing	**$0 copay**	**$0 copay**	**40% after Deductible**
Durable Medical Equipment Benefits: **Copayment/Coinsurance** **For Tiers 2 and 3 Precertification is required for equipment leased or purchased over $1,500.**	**$0 copay**	**$0 copay**	**40% after Deductible**
Subluxation/Chiropractic Care Benefits	**$15 copay** **Benefits provided by American Specialty Health Plans**	**Not covered**	**Not covered**
Acupuncture Benefits	**$15 copay** **Benefits provided by American Specialty Health Plans**	**Not covered**	**Not covered**
Vision Care **Schedule in EOC applies**	**$20 copay**	**Not covered**	**Not covered**
Hearing exam (audiologist)	**$20 copay**	**$50 copay**	**40% after Deductible**

***Certain services require Pre-Authorization or benefits will be reduced.**
Please refer to the EOC for services requiring Pre-Authorization.

Benefit	Tier 1 Referred Care Member Responsibility	Tier 2 Participating Provider Self-Referral* Member Responsibility	Tier 3 Non-Participating Provider Self Referred* Member Responsibility
Hearing Aids **Limited to 2 hearing aids every 36 months.** **$2,000 maximum for Tiers 1, 2 ,3 combined.**	**50%**	**50%**	**50% after Deductible**
Preventive Dental Benefit for children under age 12	**$20 copay**	**Not covered**	**Not covered**

***Certain services require Pre-Authorization or benefits will be reduced.**
Please refer to the EOC for services requiring Pre-Authorization.

INPATIENT BENEFITS

Benefit	Tier 1 Referred Care	Tier 2 Participating Provider Self-Referral	Tier 3 Non-Participating Provider Self Referred
Acute Care	**$250 copay**	**$500 copay**	**40% after Deductible**
Mental Health **Serious Mental Illness is covered the same as any other illness or injury.**	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Substance Abuse	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Maternity	**$250 copay**	**$500 copay**	**40% after Deductible**
Skilled Nursing Facility **For Tier 2 and 3 Combined Maximum of 240 days per calendar year**	**$0 copay**	**$500 copay**	**40% after Deductible**
Hospice	**$0 copay**	**$500 copay**	**40% after Deductible $10,000 lifetime maximum combined inpatient and outpatient.**

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit	**Member Responsibility**
Participating Retail Pharmacy (maximum 30 day supply)	
Generic Formulary Prescription Drugs	**$15**
Brand Name Formulary Prescription Drugs	**$25**
Nonformulary Prescription Drugs	**$40**
Participating Mail Order Pharmacy (31 – 90 day supply)	
Generic Formulary Prescription Drugs	**$30**
Brand Name Formulary Prescription Drugs	**$50**
Nonformulary Prescription Drugs	**$80**
Copayment Exception: Participating Retail and Mail Order	
Contraceptive Devices; Diabetic supplies	**$0**

- The **Member** is responsible for a **Copayment** in the amount of **$25.00** per prescription or refill for a **Brand Name Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$40.00** per prescription or refill for a **Non-Formulary Prescription Drug**.
- **For Prescriptions filled at Participating Mail Order Pharmacies:**
- The **Member** is responsible for a **Copayment** in the amount of **$30.00** per prescription or refill for a **Generic Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$50.00** per prescription or refill for a **Brand Name Formulary Prescription Drug**.
- The **Member** is responsible for a **Copayment** in the amount of **$80.00** per prescription or refill for a **Non-Formulary Prescription Drug**.


Aetna
US Healthcare

Your Group Plan

University of California

UC CARE IN-AREA PLAN

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2001

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations"). Portions of these Regulations are summarized below.

If you are enrolled in the UC Care plan with in-area benefits, the following information is added to your Evidence of Coverage.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare + Choice Managed Care contract is not eligible for this plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more. To remain eligible, you must maintain an average regular paid time* of at least 20 hours per week and maintain an eligible appointment of at least 50% time. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

***** For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12) month period.

(a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

(a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

Annuitant (including Survivor Annuitant): **Annuitant** A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Survivor Annuitant A deceased Employee's or Annuitant's family member receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as an **Annuitant** when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a **Survivor Annuitant** when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Annuitant medical eligibility;

(b) the effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death for a Survivor Annuitant); and

(c) you elect to continue medical coverage at the time of retirement.

If you are eligible for Medicare, see "Effect of Medicare on Annuitant Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse: Your legal spouse. (Note: if you are a Survivor Annuitant, you may not enroll your legal spouse.)

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;

(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous,

- the child is dependent on you for at least 50% of his or her support and is your dependent for income tax purposes, and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members): You may enroll an adult dependent relative or same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations. For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, an Annuitant, a Survivor Annuitant or a Family Member, but not under any combination of these. If both husband and wife are eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's coverage but not under both.

In-Area and Out-of-Area Benefits and Eligibility

This booklet describes the coverage available to persons enrolled in the in-area benefits. The out-of-area benefits are described in a separate booklet. The following describes which benefits (in-area or out-of-area) are available to eligible Employees/Annuitants and their eligible Family Members.

In-Area Eligibility

You are eligible for in-area benefits if you are an eligible Employee or Annuitant permanently living inside the Tier 1 service area. If you are eligible for in-area benefits, your Family Members are eligible only for in-area benefits unless item (c) or (d) below applies.

Out-of-Area Eligibility

You are eligible for out-of-area benefits if you are:

(a) An Employee or Annuitant permanently living outside the Tier 1 service area. All Family Members are eligible only for out-of-area benefits.

(b) A faculty member on sabbatical (not in residence) or participating in the Education Abroad Program, or staff member on professional leave outside the Tier 1 service area. Family Members are eligible for in-area benefits or may accompany you and be eligible for out-of-area benefits.

(c) A child who is a full-time student living away from home outside the Tier 1 service area during the academic year.

(d) A natural or adopted child living with an ex-spouse more than 50% of the year outside the Tier 1 service area.

The rest of the family of the children described in (c) and (d) will remain in-area.

The UC Care plan's calendar year deductibles/benefit maximums/benefit limits and its lifetime maximums are combined for members who transfer between in-area and out-of-area status.

Please Note: the following is added to the Exclusions and Limitations section of the booklet:

- Prescription drugs prescribed for sexual dysfunction are excluded unless filled at a participating pharmacy.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in.

(a) For a spouse, on the date of marriage. Survivor Annuitants may not add Spouses to their coverage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:

(i) the date you or your Spouse has the legal right to control the child's health care, or

(ii) the date the child is placed in your physical custody.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO and you move or are transferred out of that HMO's service area, or will be away from the HMO's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the HMO's service area.

At Other Times

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you or your eligible Family Members fail to enroll during a PIE or open enrollment period, you may enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-day waiting period starts on the date your enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have two or more Family Members enrolled in the Plan, you may add a newly eligible Family Member at any time. See "Effective Date".

If you are an Annuitant, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment before the effective date of retirement (or the date disability or survivor benefits begin).

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are an Annuitant continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

When you already have two or more Family Members enrolled and enroll another Family Member, coverage may be retroactive with the effective date limited to the later of:

(a) the date the newly added Family Member becomes eligible, or

(b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

Effect of Medicare on Annuitant Enrollment

If you are an Annuitant and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Annuitants and their Family Members who are eligible for premium free Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. Annuitants or Family Members who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Affidavits may be obtained from the University's Customer Service Center. (Annuitants/Family Members who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to the Annuitant Insurance unit at Office of the President.

Medicare Private Contracting Provision

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as an Annuitant by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

De-enrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are an Annuitant or Survivor Annuitant and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on de-enrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

De-enrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently de-enrolled while any other Family Member and the Subscriber will be de-enrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be de-enrolled for 18 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UCbencom website (www.ucop.edu/bencom). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Annuitant.

PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Insurance Contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
800- 888-8267

Annuitants may also direct questions to the University's Customer Service Center at the above phone number.

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2001

Claims under the Plan are processed by Aetna U.S. Healthcare of California Inc. at the following address and phone number:

Aetna U.S. Healthcare
P.O. Box 9220
Van Nuys, CA 91401-0220
800-632-0524

Mental Health & Substance Abuse Benefits

The Mental Health/Substance Abuse benefits described in this booklet are insured by United HealthCare Insurance Company and administered by United Behavioral Health (UBH). If you have a question, you may direct it to UBH at the following address:

United Behavioral Health
P.O. Box 8250
Emeryville, CA 94662-8250
888-440-8225

Group Contract Number

The Group Contract Numbers for this Plan are:

Aetna U.S. Healthcare of California	**724666**
United Behavioral Health	**11280**

Type of Plan

This Plan is a health and welfare plan that provides group health care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. The plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements

The benefits under the Plan are paid by Aetna U.S. Healthcare of California Inc. and by United Health Care Insurance Company, administered by United Behavioral Health, under an insurance contract. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on the Plan Administrator or on any of the plan claims processors at the applicable address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including the insurance contracts.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims Under the Plan

Mental Health/Substance Abuse

Claims under United Behavioral Health's Mental Health/Substance Abuse Benefit are filed by the United Behavioral Health provider. It is the responsibility of the members to obtain the pre-authorization necessary to receive services from a United Behavioral Health provider.

All Other Services

To file a claim or to appeal a denied claim, refer to the "Grievance Procedure" and "General Provisions" sections of your Evidence of Coverage.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams and for faculty to Executive Director Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

UNIVERSITY OF CALIFORNIA
AETNA U.S. HEALTHCARE EVIDENCE OF COVERAGE

AETNA U.S. HEALTHCARE OF CALIFORNIA INC.

EVIDENCE OF COVERAGE

This Evidence of Coverage ("**EOC**") is part of the Group Agreement ("**Group Agreement**") between Aetna U.S. Healthcare of California Inc., hereinafter referred to as **"Plan",** and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **EOC** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **EOC** or added thereafter.

This **EOC** provides coverage for three levels of benefits: Tier 1 coverage is provided for services provided by your **PCP** or **Referred** by your **PCP** to a **Participating Provider.** Tier 2 coverage is provided for **Non-Referred Benefits** received from **Participating Providers**. Tier 3 coverage is provided for **Non-Referred Benefits** received from **Non-Participating Providers**.

"**Plan**" means Aetna U.S. Healthcare of California Inc. a California corporation operating pursuant to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan of 1975.

The **Plan** agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **EOC**. **Members** covered under this **EOC** are subject to all the conditions and provisions of the **Group Agreement**.

This **EOC** describes covered health care benefits. Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation and Conversion section of this **EOC.**

Certain words have specific meanings when used in this **EOC**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **EOC**. Where context permits, the defined terms **Member(s)** and **Member's** have been replaced with "you" or "your" to improve ease of reading.

This EOC is not in lieu of insurance for Workers' Compensation. This EOC is governed by applicable federal law and the laws of California.

READ THIS ENTIRE EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND THE PLAN. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS EOC.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY THE PLAN.

NO SERVICES ARE COVERED UNDER THIS EOC IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE THIRTY-ONE (31) DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THIS EOC APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS EOC.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF THE PLAN. THE PLAN IS NOT THE AGENT OF ANY PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY, OR AGENCY, NEITHER THE PLAN NOR THE CONTRACT HOLDER (YOUR EMPLOYER OR GROUP) IS THE AGENT OF EACH OTHER.

AS OF JULY 1, 2001, A STATEMENT DESCRIBING AETNA U.S. HEALTHCARE OF CALIFORNIA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

PLAN PROCEDURE

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY THE PLAN.

ELIGIBILITY, COVERED BENEFITS, MEDICAL NECESSITY, PRE-AUTHORIZATION, CONCURRENT REVIEW, RETROSPECTIVE RECORD REVIEW AND ALL OTHER TERMS AND CONDITIONS OF THE MEMBER'S HEALTH PLAN ARE DETERMINED AT THE SOLE DISCRETION OF THE PLAN (OR ITS DESIGNEE). THIS MEANS THAT SOME SERVICES RECOMMENDED BY THE MEMBER'S HEALTH PROFESSIONAL MAY NOT BE COVERED BENEFITS AS DETERMINED BY THE PLAN.

A. **Tier 1 Benefits.**

Services are provided under Tier 1, when your care is provided by your **Primary Care Provider (PCP)** or **Referred** by your **PCP** to a **Participating Provider**. **Emergency Care, Urgent Care** out of the **Service Area,** and Direct Access services as described in the Covered Benefits Section of this **EOC** are the only exceptions. You are responsible for the **Copayments** shown on the Schedule of Benefits.

1. **Selecting a Participating Primary Care Physician.**

The **Plan** uses a network of independent **Participating Providers**, comprised of **Physicians**, **Hospitals** and other **Health Professionals** and facilities throughout the **Service Area**. Each **Primary Care Physician (PCP)** is associated with a **Participating Hospital** and Medical Group or IPA**.** You must use the **Hospital** with which your **Primary Care Physician** is associated except when it is **Medically Necessary** to receive services elsewhere or when obtaining certain Direct Access **Specialist** benefits as described in this **EOC.**

At the time of enrollment, you should select a **Participating Primary Care Physician** (**PCP)** from the **Plan's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **EOC**. The choice of a **PCP** is made solely by you. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. Until a **PCP** is selected, you will not receive benefits under Tier 1 except for coverage for **Medical Emergency** care or **Urgent Care** services received outside the **Plan's Service Area**.

2. **The Primary Care Physician.**

The **PCP** coordinates your medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct you to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency,** for **Urgent Care** services received outside the **Plan's Service Area** or for certain Direct Access **Specialist** benefits as described in this **EOC**, only those services which are provided by **your PCP** or **Referred** by your **PCP** to a **Participating Provider** will be covered under Tier 1. **Covered Benefits** are described in the Covered Benefits section of this **EOC**. It is your responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

3. **Changing Your PCP.**

You may change your **PCP** at any time by calling the Member Services toll-free telephone number listed on your identification card. The change will become effective upon the **Plan's** receipt and approval of the request.

4. **PCP Referrals Under Tier 1.**

To receive benefits under Tier 1 you must contact your **PCP** before seeking **Medical Services** unless you are seeking **Emergency Services**, **Urgent Care** services outside the **Plan's Service Area**, or covered direct access **Specialist** benefits. For all other services under Tier 1, you must first obtain an authorized **Referral** from your **PCP**. When you need a **Specialist**, your **PCP** will provide you with an authorized **Referral** to a **Participating Provider** within the **PCP's** associated

Medical Group or IPA, unless it is **Medically Necessary** to refer you to a **Specialist** outside of your **PCP's** Medical Group or IPA or to a **Non-Participating Provider** if there is no **Appropriately Qualified Provider** within the network. For certain services, your **PCP** must also obtain **Pre-Authorization** from the **Plan**. If the **Specialist** you visited on **Referral** from your **PCP** wants to refer you to another **Specialist**, an additional written authorized **Referral** must be obtained. Your **PCP** may decide to see you again before making a **Referral** to another **Specialist**.

5. **Requesting a Standing Referral Under Tier 1.**

If you have been diagnosed with (i) a **Life-Threatening** condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request that a **Specialist** or **Specialty Care Center** assume responsibility for providing or coordinating your medical care, including primary and specialty care. You may make this request through your **PCP** or **Specialist**. You or your **Physician** will be sent a form to be completed and returned to the **Plan** for review. If the **Plan**, or your **PCP**, in consultation with a **Plan** medical director and **Specialist**, if any, determines that your care would most appropriately be coordinated by a **Specialist** or **Specialty Care Center**, your **PCP** will authorize a **Standing Referral** to such **Specialist** or **Specialty Care Center** for up to twelve (12) months.

Any authorized **Referral** shall be made pursuant to a treatment plan approved by the **Plan** in consultation with your **PCP** (if appropriate), the **Specialist** or **Specialty Care Center**, and you or your designee. The approved **Specialist** or **Specialty Care Center** will be permitted to treat you without further **Referral** from your **PCP** and may authorize such **Referrals**, procedures, tests and other **Medical Services** as your **PCP** would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. For the purposes of this coverage, a **Specialty Care Center** means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the **Life-Threatening** disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

The **Plan** is not required to permit you to elect to have a non-participating **Specialist**, unless an **Appropriately Qualified Specialist** is not available within the **Plan's** network of **Participating Providers**. If your approved **Standing Referral** is to a nonparticipating **Provider**, services provided pursuant to the approved treatment plan will be provided at no extra cost to you beyond what you would otherwise pay for services received within the **Plan** network of **Participating Providers.**

6. **Requesting Continuity of Care Under Tier 1.**

In order to provide for the transition of **Members** with minimal disruption, the **Plan** permits a **Members** who meet certain requirements to continue an **Active Course of Treatment** with a terminated **Provider** for a transitional period of time without penalty.

The **Plan** will continue coverage for you for an ongoing **Active Course of Treatment** with your current health care **Provider** during a transitional period which shall be for ninety (90) days for acute or serious chronic conditions; until postpartum services are completed for high risk pregnant **Members**, or pregnant **Members** in their second or third trimester; or for the length of time necessary to safely transfer care, as determined by the treating **Provider** and the **Plan** in consultation, in accordance with good professional practice. In order for transitional coverage to be provided for **Covered Benefits** rendered by a continuance with the **Non-Participating Provider**, the following conditions must be met:

a. You must be receiving ongoing treatment from a terminated **Provider**.

b. You must have an acute medical condition, serious medical condition, or be in the second or third trimester of pregnancy or in a high risk pregnancy.

c. You must have begun an **Active Course of Treatment** prior to the date the formerly **Participating Provider** was terminated.

d. The terminated **Provider** must have been involuntarily terminated for reasons other than medical disciplinary action, fraud or other criminal activity.

e. The transition request must be submitted to the **Plan** within ninety (90) days from the date of discontinuation of the **Provider's** contract and prior to receiving services (except in an emergency) from the **Non-Participating Provider**; and

f. If services are received prior to the approval of transition of benefits, the services must be approved by a **Plan** Medical Director.

In order for a **Provider** to continue treating you during a transition period, the **Provider** must agree to:

a. continue to provide your treatment and follow-up care;

b. continue to share information regarding the treatment plan with the **Plan**;

c. continue to use the **Plan** network for any necessary **Referrals**, diagnostic tests or procedures or hospitalizations;

d. continue to accept the **Plan** capitation rates and/or similar fee schedules as other non-capitated **Providers** in the same geographic area for similar services and to;

e. continue to abide by the terms and conditions of the prior contract.

You may request a "Continuity of Care Form" by calling the toll-free Member Services telephone number listed on your ID card and requesting the form. You and your treating **Physician** fill out and submit the Continuity of Care Form within the time frames described above. This continuity of care provision shall not be construed to require the **Plan** to provide coverage for services not otherwise covered by the **Plan** under this **EOC**.

7. **Facilities.**

Your selection of a **Primary Care Physician** determines the **Hospital** or **Skilled Nursing Facility** to which you will be admitted for coverage under Tier 1 unless it is **Medically Necessary** to receive **Hospital** services elsewhere.

A **Provider** directory listing **Participating Hospitals**, laboratories, pharmacies, **Skilled Nursing Facilities**, home health agencies and other ancillary health care and subacute facilities will be distributed to **Members**. If another copy of the directory is needed, you may call the **Contract Holder** or Member Services at the toll free telephone number listed on your identification card. The list of **Participating Providers** is subject to change.

B. **Tier 2 Benefits.**

Services are covered under the Tier 2 level of benefits when you seek care from a **Participating Provider** without a **Referral** from your **PCP** (**Non-Referred** or **Self-Referred** care**)**. Certain services and supplies under this **EOC** may require **Pre-Authorization** by the **Plan** to determine if they are **Covered Benefits** under this **EOC**. Your **Participating Provider** should contact the **Plan** for the necessary **Pre-Authorization**.

Some **Covered Benefits** under Tier 1 may not be **Covered Benefits** under Tier 2.

C. **Tier 3 Benefits.**

Services are covered under the Tier 3 level of benefits when you seek care from **Non-Participating Providers** without a **Referral** from your **PCP.** Certain services and supplies under this **EOC** may require **Pre-Authorization** by the **Plan** to determine if they are **Covered Benefits** under this **EOC.** You are responsible for obtaining the necessary **Pre-Authorization** from the **Plan.** If you do not obtain the required **Pre-Authorization**, your coverage under Tier 3 will be reduced by the **Pre-Authorization Penalty** shown on the Schedule of Benefits.

Some **Covered Benefits** under Tier 1 may not be **Covered Benefits** under Tier 3.

D. **Pre-Authorization.**

1. Certain services and supplies under this **EOC** may require **Pre-Authorization** by the **Plan** to determine if they are **Covered Benefits** under this **EOC**.

2. For additional information regarding the **Pre-Authorization** process, you may contact Member Services at the toll-free number on your identification card.

3. **Under Tier 1**, your **PCP** is responsible for coordinating your health care, either by treating you directly or by referring you to a **Participating Specialist**. Your **PCP** is responsible for obtaining any necessary **Pre-Authorization** from the **Plan.**

4. **Under Tier 2,** your **Participating Provider** is responsible for obtaining the necessary **Pre-Authorization** from the **Plan.**

5. **Pre-Authorization Under Tier 3.**

   Under Tier 3 you are responsible for obtaining the necessary **Pre-Authorization.** If you do not obtain the necessary **Pre-Authorization,** coverage for the services will be reduced by the **Pre-Authorization** penalty shown on the Schedule of Benefits. The services requiring **Pre-Authorization** are:

   - Outpatient surgery
   - Outpatient diagnostic tests not normally performed in a **Physician's** office (such as MRI/MRA/PET)
   - **Durable Medical Equipment** over $1,500
   - **Home Health**
   - Inpatient and outpatient **Hospice**
   - Inpatient **Hospital**
   - Maternity
   - Organ transplants
   - Outpatient rehabilitation therapies (e.g. speech, physical, occupational)
   - Private duty nursing
   - Skilled nursing

   You, or a member of your family, a **Hospital** staff member, or your attending **Physician**, must notify the **Plan** to **Pre-Authorize** the admission or treatment, as the case may be, prior to receiving any of the services or supplies that require **Pre-Authorization**.

   To obtain **Pre-Authorization**, call the **Plan** at the toll-free telephone number listed on the your identification card. This call must be made:

   a. at least fourteen (14) days prior to any planned admission into a **Hospital** and prior to receiving such other services that require **Pre-Authorization**;

   b. within twenty-four (24) hours after the time of an emergency admission or as soon thereafter as reasonably possible; and

   c. as soon as possible after the attending **Physician** confirms that you are pregnant and again within twenty-four (24) hours of the birth or as soon thereafter as possible.

   You may request a review of the **Plan's Pre-Authorization** decision as explained in the Grievance Procedure section of this **EOC**. If your request for **Pre-Authorization** is denied, reduced or modified due to a determination that all or part of the requested procedure is a **Disputed Health Care Service,** the **Plan** will include in the notification an explanation of your rights to request an independent medical review of the **Plan's** decision. This explanation will

include an envelope addressed to the Department of Managed Health Care, a form for requesting independent medical review, and instructions for completing the form. Please refer to the Grievance Procedure section of this **EOC** for additional information about this process.

The **Plan** will reduce the benefits payable under this **EOC** by the percentage amount set forth on the Schedule of Benefits if the procedures for **Pre-Authorization** set forth in **EOC** are not followed. You will be responsible to pay the unpaid balance of the benefits.

FAILURE TO OBTAIN PRE-AUTHORIZATION WILL RESULT IN A REDUCTION OF BENEFITS UNDER TIER 3. PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR THE PRE-AUTHORIZATION PENALTY.

The additional percentage or dollar amount of the **Reasonable Charge** which you may pay as a penalty for failure to obtain **Pre-Authorization** under this section is not a **Covered Expense**, and will not be applied to the **Deductible** amount or the maximum out-of-pocket limit.

E. **Ongoing Reviews.**

The **Plan** conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **EOC**. If the **Plan** determines that the recommended services and supplies are not **Covered Benefits**, you will be notified. If you wish to appeal such determination, you may then contact Member Services at the toll-free number on your identification card to seek a review of the determination.

The management of your healthcare through ongoing reviews employs a consistent set of integrated medical management tools. The process consists of the management of your **Referrals** by the **PCP** to other **Health Professionals**; the review of the **Medical Necessity** and appropriateness of inpatient admissions as well as outpatient tests and procedures; monitoring of inpatient services once admitted; and the transitioning from inpatient to outpatient services. For additional information about this process please contact Member Services at the toll-free number on your identification card.

F. **Provider Compensation.**

PCPs and **Providers** may be paid in any of the following ways: depending upon the type of contract they have with the **Plan.**

1. A fixed price per service.
2. A fixed price per day.
3. A fee for each service set by a fee schedule.
4. A fixed monthly amount per **Member**.

Providers contracted with the **Plan** have no requirement to comply with specified numbers, targeted averages or maximum duration for patient visits Compensation arrangements are designed to encourage the provision of the most appropriate care for each **Member** and to discourage the provision of unnecessary, and potentially detrimental services. When **Providers** are paid a fixed monthly amount per **Member**, the **Plan** incorporates specific "quality factors" into the compensation process. **Provider** compensation is adjusted based on results in various areas, including: appropriate diagnostic testing, specialty and **Hospital** utilization; **Member** satisfaction survey results; thoroughness of medical chart documentation; clinical care measures for diabetes, asthma and other conditions; number of scheduled office hours; range of office procedures offered; around the clock coverage; and participation in continuing education programs. **Members** are encouraged to ask **Physicians** and other **Providers** how they are compensated in their individual cases, including whether their arrangements include any financial incentives.

If your **Provider** performs, suggests, or recommends you for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be your responsibility.

G. **Availability of Providers.**

The **Plan** cannot guarantee the availability or continued participation of a particular **Provider**. Either the **Plan** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members**

that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another **PCP** selection. You must then cooperate with the **Plan** to select another **PCP**. Under Tier 1, until a **PCP** is selected benefits are limited to coverage for **Medical Emergency** care or **Urgent Care** services received outside the **Plan's Service Area**.

H. **Second Opinion.**

If you request a second opinion about a proposed surgery or course of treatment, the **Plan** will authorize a second medical opinion regarding a proposed surgery or course of treatment recommended by your **PCP** or a **Specialist.** For coverage under Tier 1 second opinions must be obtained from a **Participating Provider.** If there is no **Appropriately Qualified Participating Provider** in the network, the **Plan** will authorize a **Referral** to an **Appropriately Qualified Provider** outside the network. To request a second opinion, you should contact the **Plan** at the toll-free number listed on your ID card or your **PCP** for a **Referral**. In cases where access to a second opinion should be expedited due to imminent and serious health threat, the **Plan** will respond to your request for a second opinion within seventy-two (72) hours of receiving the request. For additional information regarding second opinions including copies of the **Plan's** timelines for responding to requests for second opinions, you may contact Member Services at the toll free telephone number listed on your ID card.

I. **Liability of Member for Payment Under Tier 1.**

All non-**Emergency Services** must be provided by your **Primary Care Physician**, your **PCP's** on-call **Physician**, or a **Participating Provider** referred by your **PCP** except for certain direct access **Specialist** benefits as described in the Covered Benefits section of the **EOC** or **Urgent Care** services received outside the **Plan Service Area**. You are responsible for the **Copayments** listed in the Schedule of Benefits.

If you seek care, other than covered direct access **Specialist** benefits, from a **Provider** other than your **PCP** without a **Referral**, coverage will be provided under Tiers 2 or 3. Coverage for services of a **Physician** or other **Health Professional** who is not a **Participating Provider** requires **Pre-Authorization** before the service or supply is covered under Tier 1, except for **Emergency Services** or **Urgent Care** services received outside the **Plan's Service Area**. If the **Plan** denies payment to a non-**Participating Provider**, you will be liable for the increased out-of-pocket costs of services covered under Tier 2 or 3.

The **Plan's** contracts with its **Participating Providers** specify that, except for **Copayments**, **Members** are not liable for payment for **Medically Necessary Covered Benefits** which have the appropriate **Pre-Authorization**, even if the **Plan** fails to pay the **Participating Provider**.

J. **Deductible and Out-of-Pocket Limits.**

Benefits received under Tier 1, and **Non-Referred Benefits** received under Tiers 2 and 3, do not duplicate each other. A service or supply which is a **Covered Benefit** under the Tier 1 is not always a **Covered Benefit** under Tiers 2 and 3. Any **Plan** benefits that a you receive under Tier 1, and any benefits that you receive under Tiers 2 and 3, will be combined when calculating the maximum benefits which you are entitled to receive under this **EOC**. Benefit limits offset and do not duplicate each other. The benefits provided under Tiers 2 and 3 are offered only in conjunction with and as a supplement to the benefits provided under Tier 1. Any Tier 1 benefits covered by a rider to the **EOC** are excluded from coverage under Tiers 2 and 3, unless such services are specifically included in the Covered Benefits section of the **EOC**.

Copayments paid by **Members** for **Referred** benefits received under Tier 1 of this **EOC**, including any riders, shall not apply in satisfying the **Deductible** or out-of-pocket maximums under Tiers 2 and 3. **Copayments** under Tier 2, and **Coinsurance** and satisfaction of the **Deductible** under Tier 3 combine to apply toward the satisfaction of the maximum out-of-pockets limits shown in the Schedule of Benefits for Tiers 2 and 3.

K. **Liability for Payment: Deductibles, Coinsurance And Copayment Under Tiers 2 and 3.**

1. **Self-Referral to a Participating Provider - Tier 2.**

Coverage for services provided by a **Participating Provider** will be available without a **Referral** from the **Member's Primary Care Physician** when:

a. you elect to obtain **Covered Benefits** from a **Participating Provider**; and

b. you pay the required **Copayment** set forth on the Schedule of Benefits.

2. **The Deductible - Tier 3.**

You first must satisfy the **Deductible** amount, if any, listed on the Schedule of Benefits before **Covered Expenses** are reimbursed. Thereafter, you must pay a **Coinsurance** portion of the **Covered Expenses** for **Non-Referred Benefits** that you receive.

- The **Deductible** applies to each **Member**, subject to any family **Deductible** listed on the Schedule of Benefits. For purposes of the **Deductible**, "family" means the **Subscriber** and **Covered Dependents**.

3. **The Coinsurance Tier 3.**

After the **Deductible** amount has been satisfied, the **Plan** will pay the percentage of the **Reasonable Charges** for **Covered Expenses** set forth in the Covered Benefits section of this **EOC**.

4. **Charges in Excess of the Reasonable Charge - Tier 3.**

The **Member** will be responsible for charges in excess of the **Plan's** contractual liability under this **EOC**. Charges by a **Provider** in excess of the **Reasonable Charge** will not be covered by the **Plan** and will not be counted toward the **Member's Deductible** amount or maximum out-of-pocket limit shown on the Schedule of Benefits.

5. **Calculations; Determination of Reasonable Charge; Determination of Benefits.**

A **Member's** financial responsibility for the costs of care will be calculated on the basis of when the service or supply is provided, not when payment is made. Charges will be prorated to account for treatment or portions of stays that occur in more than one calendar year. The **Plan** reserves the right and sole discretion to determine the **Reasonable Charge**. It is solely within the discretion of the **Plan** to determine when expenses are covered under this **EOC**.

6. **Maximum Out-of-Pocket Limit.**

If your **Copayments** or **Coinsurance** payments reach the maximum out-of-pocket limit set forth on the Schedule of Benefits, the **Plan** will pay 100% of the **Reasonable Charges** for **Covered Benefits** during that calendar year, up to the Maximum Benefit listed on the Schedule of Benefits. You must receive the **Covered Benefits** that calendar year. Charges in excess of the **Reasonable Charges** will not be covered and the additional percentage of **Reasonable Charges** which you may pay as a penalty for failure to obtain **Pre-Authorization** will not be applied to the maximum out-of-pocket limit and not eligible for 100% reimbursement.

7. **Benefit Limitations.**

The **Plan** will provide coverage to **Members** up to the Maximum Benefit for all Services and Supplies set forth on the Schedule of Benefits. **Covered Benefits** whose **Covered Expenses** have been applied toward satisfaction of the **Deductible** will be counted toward any applicable day or visit maximums for **Covered Benefits** under this **EOC.**

FEES AND CHARGES

A. **Premiums.**

The **Contract Holder** is responsible for advance payment of **Premiums** for **Plan** coverage in accordance with the **Group Agreement**. **Subscribers** may be required to pay a portion of such **Premiums**. If so, you will be notified by the **Contract Holder**.

Coverage is only provided for **Members** whose **Premiums** have been received by the **Plan**. Coverage extends only for the period for which such payment is received, subject to any allowances stated in the **Group Agreement**.

B. **Other Charges.**

You will be required to make certain **Copayments** or **Coinsurance** for **Covered Benefits** as specified in the Schedule of Benefits. **Copayments** must be paid at the time the **Covered Benefits** are rendered. The total aggregate amount you are required to pay per year is specified under the out-of-pocket maximum in the Schedule of Benefits. It is your responsibility to keep your **Copayment** and **Coinsurance** receipts and to notify the **Plan** when you have exceeded the out-of-pocket maximum under Tiers 1, 2 or 3. In the event you pay a **Copayment** or **Coinsurance** above the out-of-pocket maximum the amount paid is reimbursable upon submission of evidence of payment within forty-five (45) days after the end of the **Contract Year**.

You will also be responsible for any charges made by **Providers** for scheduled appointments that are missed without notice to the **Providers** or without good cause. Personal administrative service costs such as copying **Member** medical records or completing forms for school, camp, employment, etc. are also your responsibility.

ELIGIBILITY AND ENROLLMENT

Please refer to the University of California Eligibility, Enrollment, Termination and Plan Administration Section (Part I), page 1of this booklet.

A. **Effective Date of Coverage**.

Please refer to the University of California Eligibility, Enrollment, Termination and Plan Administration Section (Part I) on page 5 of this booklet.

B. **Hospital Confinement on Effective Date of Coverage.**

If you are an inpatient in a **Hospital** on the **Effective Date of Coverage**, you will be covered as of that date. Such services are not covered if you are covered by another health plan on that date and the other health plan is responsible for the cost of the services. The **Plan** will not cover any service that is not a **Covered Benefit** under this **EOC**. Coverage is subject to all the terms and conditions of this **EOC**.

C. **Renewal Provisions.**

If the **Contract Holder** has renewed the **Group Agreement,** and you are still eligible for coverage under this plan, you may renew coverage under the same **Group Agreement,** if all **Premiums** have been properly paid and you meet the eligibility requirements. Such annual renewal is automatic and reapplication is not necessary. **Premiums** may change upon renewal. If coverage for the **Subscriber** and **Covered Dependents** is terminated, **Subscriber** must submit a new application.

COVERED BENEFITS

You shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **EOC** and Schedule of Benefits. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary** and the **Covered Benefit** must be performed by a **Provider** that is licensed to perform such services. For the purpose of coverage, the **Plan** may determine whether any benefit provided under the **EOC** is **Medically Necessary**, and, under Tier 1, the **Plan** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by the **Plan**;

- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital Services**; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, the **Plan's** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member's** health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to the **Plan's** attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by the **Plan**.

If you have questions regarding coverage under this **EOC**, you may call the Member Services toll free telephone number listed on your identification card.

YOU ARE RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS OR COINSURANCE AND DEDUCTIBLE LISTED ON THE SCHEDULE OF BENEFITS.

IN ORDER TO BE COVERED UNDER TIER 1, EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS EOC, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON YOUR IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY YOUR PCP. NOT ALL COVERED BENEFITS LISTED BELOW ARE COVERED UNDER TIERS 2 AND 3.

IMPORTANT: REFER TO THE PLAN PROCEDURE SECTION, PRE-AUTHORIZATION, OF THIS CERTIFICATE FOR THE LIST OF SERVICES WHICH REQUIRE PRE-AUTHORIZATION.

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.
2. Home visits.
3. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. If you become sick or injured after the **PCP's** regular office hours, you should:
   a. call the **PCP's** office; and
   b. identify yourself as a **Member**; and

c. follow the **PCP's** or covering **Physician's** instructions.

If your injury or illness is a **Medical Emergency**, you should follow the procedures outlined under the Emergency Care/Urgent Care Benefits section of this **EOC**.

4. **Hospital** visits.

5. Periodic health evaluations to include:

   a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services. Screening tests for blood lead levels of a **Covered Dependent** child at risk for lead poisoning are also covered.

   b. routine physical examinations, including, 1) services related to the diagnosis, treatment and appropriate management of osteoporosis and 2) the screening and diagnosis of prostate cancer, including but not limited to, prostate-specific antigen testing and digital rectal examinations, when **Medically Necessary** and consistent with good medical practice.

   c. routine gynecological examinations, including pap smears and related laboratory services, for routine care, administered by the **PCP**. The **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access **Specialist** Benefits section of this **EOC** for a description of the requirements for Direct Access.

   d. routine hearing screenings through age 18.

   e. immunizations (but not if solely for the purpose of employment, unless recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention).

   f. annual routine vision screenings for the purpose of determining vision loss.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information, including family planning, health education services and guidance, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.

9. IUD device insertion. Removal is covered based on **Medical Necessity**.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.

   Coverage is also provided for tests which are ordered by a **Physician** and given to you prior to your admission to a **Hospital** as a registered bed inpatient. The tests must be necessary and consistent with the diagnosis and treatment of the condition for which **Hospital** care is required. The **Hospital** admission must take place within fourteen (14) days after the tests are given, unless such tests or other medical condition indicate otherwise. Benefits will be covered under Tier 2 if the your **Participating Provider** ordered your tests from a **Participating Facility.** Benefits will be covered under Tier 3 if the tests are given at a **Non-Participating Facility.**

2. mammograms. In order to be covered under Tier 1, you are required to obtain a **Referral** from your **PCP** or gynecologist, or receive **Pre-Authorization** from the **Plan** to a **Participating Provider**, prior to receiving this benefit.

   Screening mammogram benefits for female **Members** are provided as follows:

   - ages thirty-five (35) to thirty-nine (39), one baseline mammogram;
   - age forty (40) and older, one (1) routine mammogram every year; or
   - when **Medically Necessary**.

3. **Medically Necessary** cancer screening tests which are generally accepted by the **Medical Community**.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider** other than the **Member's PCP**.

1. Direct Access to Gynecologists includes a routine gynecological examination and pap smear, and benefits provided to female **Members** for services performed by their **PCP** or a **Participating** or **Non-Participating** gynecologist for diagnosis and treatment of gynecological problems. The maximum number of visits for the routine gynecological examination and Pap smear is listed on the Schedule of Benefits. Norplant and IUDs are covered when obtained from a **Participating Physician**. The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any. Only **Medically Necessary** removal is covered under Tier III.

   You must directly access a **Participating** gynecologist or obstetrician in your **PCP's** Medical Group or IPA for the services to be covered under Tier 1. If you **Self-Refer** to a **Participating** obstetrician or gynecologist who is not affiliated with your PCP's Medical Group or IPA, the services will be covered under Tier 2 If you self-refer to a **Non-Participating** gynecologist or obstetrician your benefits will be covered under Tier 3.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

2. Routine Eye Examinations are covered as shown below without a **Referral** when rendered by a **Provider** identified in the **Provider** Directory as participating in the Direct Access Eye program. Routine eye examinations are not covered under Tiers 2 and 3.

   Routine Eye Examinations, including refraction, as follows:

   a. if **Member** is age one (1) through eighteen (18) and wears eyeglasses or contact lenses, one (1) exam every twelve (12)-month period.

   b. if **Member** is age nineteen (19) and over and wears eyeglasses or contact lenses, one (1) exam every twenty-four (24)-month period.

c. if **Member** is age one (1) through forty-five (45) and does not wear eyeglasses or contact lenses, one (1) exam every thirty-six (36)-month period.

d. if **Member** is age forty-six (46) and over and does not wear eyeglasses or contact lenses, one (one) exam every twenty-four (24)-month period.

3. Preventive Dental Care for **Members** under the age of twelve (12). Preventive Dental care is not covered under Tiers 2 and 3. **Covered Benefits** under Tier 1 are limited to:

   a. Oral prophylaxis (cleaning) as necessary;

   b. Topical application of fluorides and the prescription of fluorides for systematic use when not available in the community water supply; and

   c. Oral examination and hygiene instruction.

4. **Subluxation/Chiropractic Care Benefits** are covered under Tier 1 only, without a **Referral** when rendered by a **Participating Provider** listed in the **Provider** Directory or contact Member Services at the toll-free number listed on your ID card. Services must be **Medically Necessary** and consistent with the **Plan's** guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by a **Participating** radiologist. This benefit is not available under Tiers 2 and 3.

E. **Maternity Care and Related Newborn Care.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services are a **Covered Benefit**, including prenatal genetic testing of a fetus associated with high risk pregnancies, and voluntary participation in the Expanded Alpha Feto Protein (AFP) program, which is a California statewide prenatal testing program administered by the State Department of Health Services. To be covered for these benefits under Tier 1, you must choose a **Participating Provider** in your **PCP's** IPA or Medical Group. To be covered for these benefits under Tier 2, you must choose a **Participating Provider**. If you choose a **Non-Participating Provider**, you will be covered for these benefits under Tier 3. Please contact the **Plan** of your **Provider** choice by calling the Member Services toll free telephone number listed on your identification card, prior to receiving services.

As an exception to the **Medically Necessary** requirements of this **EOC**, the following coverage is provided for a mother and newly born child:

1. a minimum of forty-eight (48) hours of inpatient care in a **Hospital** following a vaginal delivery;

2. a minimum of ninety-six (96) hours of inpatient care in a **Hospital** following a cesarean section; or

3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the attending **Providers** in consultation with the mother.

   If you request a shorter **Hospital** stay, you will be covered for one home health care visit scheduled to occur within twenty-four (24) hours of discharge. An additional visit will be covered when prescribed by the **Participating Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

Coverage for your **Hospital** stay will be under Tier 1 when **Referred** by your PCP, under Tier 2 when you **Self-Refer** to a **Participating Hospital**, and under Tier 3 when you **Self-Refer** to a **Non-Participating Hospital.**

Coverage under Tier 1 does not include routine maternity care (including delivery) received while outside the S**ervice Area** unless you receive **Pre-Authorization** from the **Plan**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

F. **Inpatient Hospital Benefits.**

Under Tiers 1 and 2 you are covered for services only at **Participating Hospitals** except in a **Medical Emergency**, as outlined under the Emergency Care/Urgent Care benefits section of this **EOC**. If you **Self-Refer** to a **Non-Participating Hospital** service will be covered under Tier 3. In the event that you elect to remain in the **Hospital** after the date that your attending **Provider** and/or the **Plan's** Medical Director has determined and advised you that you no longer meet the criteria for continued inpatient confinement, you shall be fully responsible for direct payment to the **Hospital** for such additional **Hospital, Physician** and other **Provider** services, and the **Plan** shall not be financially responsible for such additional services.

All services are subject to **Pre-Authorization** by the **Plan**.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

G. **Skilled Nursing Facility Benefits.**

You are covered for services at **Participating Skilled Nursing Facilities** with you **PCP's Referral** under Tier 1. If you **Self-Refer** to a **Participating Skilled Nursing Facility,** services will be covered under Tier 2. If you **Self-Refer** to a **Non-Participating Skilled Nursing Facility**, services will be covered under Tier 3. In the event that you elect to remain in the **Skilled Nursing Facility** after the date that your **Provider** and/or the **Plan** Medical Director has determined and advised you that you no longer meet the criteria for continued inpatient confinement, you shall be fully responsible for direct payment to the **Skilled Nursing Facility** for such additional **Skilled Nursing Facility, Physician,** and other **Health Professional** services, and the **Plan** shall not be financially responsible for such additional services.

Coverage for **Skilled Nursing Facility** is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

All Services and supplies are subject to **Pre-authorization** by the **Plan.**

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

H**. Transplants.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. To receive benefits under Tier 1, covered transplants must be ordered by your **PCP** and **Participating Specialist Physician** and approved by the **Plan's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by the **Plan** to perform these procedures. If you **Self-Refer,** the transplant must be **Pre-Authorized** and benefits will be covered under Tier 2 for **Participating Providers**, and Tier 3 for **Non-Participating Providers.** A transplant is non-experimental and non-investigational under this **EOC** when the **Plan** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for your specific condition. Certain transplants which are **Experimental or Investigational** may be covered if approved in advance by the **Plan.** For additional information about the criteria and process for approval of **Experimental and Investigational** transplants call Member Services at the toll free number listed on your ID Card. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

All services and supplies are subject to **Pre-authorization** by the **Plan**.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

I. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure. When furnished by a **Participating** outpatient surgery center, benefits will be covered under

Tier 1 if your **PCP** has referred you and Tier 2 if you have **Self-Referred. Covered Expenses** will be covered under Tier 3 if you **Self-Refer** to a **Non-Participating Provider**.

All services and supplies are subject to **Pre-Authorization** by the **Plan**.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

J. **Substance Abuse Benefits.**

Substance Abuse Benefits are provided by United Behavioral Health (UBH) through a separate contract between the **Plan,** UBH and the **Contract Holder.** All **Substance Abuse** Benefits must be obtained through UBH, in accordance with their requirements. For additional information about your **Substance Abuse** benefits and how to access these benefits please refer to the UBH section of this booklet.

K. **Mental Health Benefits.**

The diagnosis and **Medically Necessary** inpatient and outpatient treatment of **Serious Mental Illness** and **Serious Emotional Disturbances of a Child** are covered under the same terms and conditions as any other medical condition.

All mental health benefits are provided by United Behavioral Health (UBH) through a separate contract between the **Plan**, UBH and the **Contract Holder.** All mental health benefits must be obtained through UBH, in accordance with their requirements. For additional information about your **Covered Benefits** and how to access these benefits please refer to the United Behavioral Health Certificate, (Part III page 3) of this booklet. The **Contract Holder** and the **Plan** contractually agree that if UBH ceases to provide coverage for **Serious Mental Illness** and **Serious Emotional Disturbances of a Child**, for whatever reason, the **Plan** will provide coverage through it's **Participating Behavioral Health Providers.**

In the event that the **Plan** provides coverage for mental health benefits, Mental **Health Benefits** may be provided by the **Plan** or an independently contracted organization. The **Plan** or the independently contracted organization makes initial coverage determinations and coordinates **Referrals**. Any behavioral health care **Referrals** will generally be made to **Providers** affiliated with the contracted organization, unless the **Member's** needs for covered services extend beyond the capability of **Participating Providers**.

The **Plan**, or its contractor, will use **Pre-Authorizations** and ongoing reviews (see **Plan** Procedure Sections Ongoing Reviews and Referrals and **Pre-Authorizations** above) to limit the number of inpatient days, outpatient or home health mental health visits to the minimum it deems to be **Covered Benefits** that are **Medically Necessary** mental health services regardless of the maximum number of inpatient days or outpatient visits described in the Schedule of Benefits. This means the **Member** may not receive the maximum number of visits specified in the Schedule of Benefits, or the number of days or visits the **Member** and the treating **Provider** believe to be appropriate, for a single course of treatment or episode.

Mental health benefits, if provided by the **Plan,** will only be covered under Tier 1.

All services and supplies are subject to **Pre-Authorization** by the **Plan.**

L. **Emergency Services/Urgent Care Benefits.**

1. You are covered for **Emergency Services**, provided the service is a **Covered Benefit**, and the **Plan's** medical review determines that your symptoms were such that a prudent layperson, possessing average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to their health, or if she were pregnant**,** her health and the health of her unborn child.

   The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that you were referred for such visit by your **PCP** for services that should have been rendered in the **PCP's** office or if you are admitted into the **Hospital**.

   You will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **Plan's Service Area**, for those expenses, less **Copayments**, which are incurred up to the time you are determined by the **Plan** and the attending

Physician to be medically able to travel or to be transported to a **Participating Provider**. If you choose to remain at a non-participating facility after the **Plan** and the attending **Physician** have determined that you are medically able to travel or be transported to a **Participating Provider**, any additional charges will be covered under Tier 3. In the event that transportation is **Medically Necessary**, you will be reimbursed for the cost as determined by the **Plan**, minus any applicable **Copayments**. Reimbursement may be subject to payment by you of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency** if you reasonably believed that the medical condition was a **Medical Emergency** and reasonably believed that the condition required ambulance transport services.

Members are encouraged to appropriately use the 911 emergency response system when a **Medical Emergency** requires emergency response. If the situation is not a **Medical Emergency** please, call your **PCP** for instructions. Your **PCP** is required to provide coverage twenty-four (24) hours a day, including weekends and holidays.

2. You will be covered for **Urgent Care** services obtained from a licensed **Physician** or facility outside of the **Service Area** if:

   a. the service is a **Covered Benefit**;

   b. the service is **Medically Necessary** and immediately required because of unforeseen illness, injury, or condition; and

   c. it was not reasonable, given the circumstances, for you to return to the **Plan's Service Area** for treatment.

3. While out of the **Service Area**, you are covered under Tier 1 for any follow-up care which is approved by your **PCP**. Follow-up care is any care directly related to the need for emergency care or **Urgent Care** which is provided to you after the **Medical Emergency** care or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by your **PCP** in order to be covered as a Tier 1 benefit. You must follow this procedure, or **Urgent Care** services will not be covered as a Tier 1 benefit.

M. **Rehabilitation Benefits.**

The following benefits are covered under Tier 1 upon **Referral** issued by your **PCP** and approved by the **Plan** in advance of treatment. If you **Self-Refer** to a **Participating Provider** and receive **Pre-Authorization** from the **Plan** in advance of treatment, the following benefits will be covered under Tier 2. If you self-refer to a **Non-Participating Provider** and receive **Pre-Authorization** from the **Plan** in advance of treatment**,** the following benefits will be covered under Tier 3.

1. Inpatient and Outpatient Rehabilitation Benefits.

   a. Cardiac rehabilitation benefits are available as part of your inpatient **Hospital** stay. A limited course of outpatient cardiac rehabilitation is covered when **Medically Necessary** following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

   b. Pulmonary rehabilitation benefits are available as part of your inpatient **Hospital** stay. A limited course of outpatient pulmonary rehabilitation is covered when **Medically Necessary** for the treatment of reversible pulmonary disease states.

   c. Cognitive therapy associated with physical rehabilitation is covered for acute illnesses and injuries and the acute phase of chronic conditions if treatment is expected to result in significant improvement, as part of a treatment plan coordinated with the **Plan**.

   d. Physical therapy is covered for acute illnesses and injuries and the acute phase of chronic conditions if treatment is expected to result in significant improvement.

e. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for acute illnesses and the acute phase of chronic conditions if treatment is expected to result in significant improvement.

f. Speech therapy is covered for acute illnesses and injuries and the acute phase of chronic conditions if treatment is expected to result in significant improvement. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered.

g. Additional outpatient rehabilitation benefits beyond the limits, if any, shown on the Schedule of Benefits may be approved by the **Plan** if the Medical Director determines that the services in a, b, c, or d above, when directed and monitored by a **Provider**, will result in significant improvement to your condition.

All services are subject to **Pre-Authorization** by the **Plan**. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

Copayments, Coinsurance and **Deductibles** listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

N. **Home Health Benefits.**

The following services are covered under Tier 1 with your PCP's **Referral** and under Tier 2 upon **Self-Referral** when rendered by a **Participating** home health care agency. If you **Self-Refer** to an **Non-Participating** home health care agency, services are covered under Tier 3. **Pre-authorization** must be obtained by your attending **Participating Physician** or from the **Plan** if you **Self Referred** to a **Non-Participating Provider** in advance of treatment. The **Plan** shall not be required to provide home health benefits when the **Plan** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care. Coverage is subject to the maximum number of visits shown on the Schedule of Benefits.

1. **Skilled Care** nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.

2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.

3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. Under Tier 1, the **PCP** must certify that such services are necessary for the treatment of your medical condition.

4. Short-term physical, speech, or occupational therapy is covered. Services are subject to the limitations listed in the Rehabilitation Benefits section of this **EOC**.

All services and supplies are subject to **Pre-Authorization** by the **Plan.**

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

O. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when **Pre-Authorized** by the **Plan**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family member; inpatient care; counseling including bereavement counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for funeral arrangements, pastoral counseling, financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family,

transportation, house cleaning, and maintenance of the house are not covered. Coverage is not provided for **Respite Care**.

All services and supplies are subject to **Pre-Authorization** by the **Plan.**

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

P. **Prosthetic and Orthotic Appliances.**

Covered Benefits for prosthetic and orthotic appliances include the initial provision or replacement of a **Medically Necessary** prosthetic device or custom fitted orthotics that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects, when such device is prescribed by a **Provider.** This benefit includes the provision of prosthetic devices a) to restore and achieve symmetry incident to a mastectomy due to diagnosed breast cancer or other breast disease or, b) subsequent to a laryngectomy. Coverage does not include electronic voice producing machines.

Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for you to properly use the item (such as attachment or insertion) are covered. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **EOC.** The **Plan** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

Coverage under Tier 1 requires **PCP Referral** and services must be provided by a **Participating** or designated **Provider**. Coverage under Tier 2 requires that you utilize **Participating Providers.** If you use **Non-Participating Providers** coverage will be provided under Tier 3.

All services and supplies are subject to **Pre-Authorization** by the **Plan.**

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

Q. **Injectable Medications.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **EOC**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and approved in advance of treatment by the **Plan**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at a **Plan Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

All services and supplies are subject to **Pre-Authorization** by the **Plan.**

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1) or **Self-Refer** to a **Participating Provider** (Tier 2).

R. **Mastectomy and Reconstructive Breast Surgery.**

Coverage for a mastectomy shall include a) coverage for all complications from a mastectomy including **Medically Necessary** physical therapy to treat the complications of mastectomy, including lymphedema, b) prosthetic devices, or c) reconstruction of the breast on which the mastectomy is performed including areolar reconstruction and the insertion of a breast implant and surgery and reconstruction performed on the

non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed.

The length of **Hospital** stay for mastectomies and lymph node dissections shall be determined by the attending **Physician** and surgeon in consultation with the patient and consistent with sound clinical practices.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

All services and supplies are subject to **Pre-Authorization** by the Plan.

S. **Reconstructive Surgery.**

Reconstructive Surgery, performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease is covered when:

1. **Pre-Authorization** is requested and approved by the **Plan** in advance of the service,
2. the requested surgery will improve function or create a normal appearance to the extent possible,
3. there is no more appropriate surgical procedure which will be approved for you,
4. if the proposed surgery or surgeries offer more than a minimal improvement in your appearance.

Pre-authorization decisions, including determining whether **Reconstructive Surgery** will produce more than a minimal improvement in your appearance**,** shall be made by the **Plan Medical Director** or delegate who is a licensed **Physician** competent to evaluate the specific clinical issues involved in the care requested, based upon the standards of care practiced by **Physicians** specializing in the type of reconstructive surgery. This means, for example, that for a treatment request submitted by a podiatrist or an oral and maxillofacial surgeon, the request will be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

When the conditions listed above are met, services will be covered at Tier 1 with **PCP Referral**, at Tier 2 when you **Self-Refer** to a **Participating Provider,** and at Tier 3 when you **Self-Refer** to a **Non-Participating Provider.**

All services and supplies are subject to **Pre-Authorization.**

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

T. **Limited General Anesthesia for Dental Procedures.**

General anesthesia and associated facility charges for dental procedures rendered in a **Hospital** or surgery center are covered when:

1. **Pre-Authorized** by the **Plan,**
2. the clinical status or underlying medical condition of the **Member** requires dental procedures that ordinarily would not require general anesthesia to be rendered in a **Hospital** or surgery center, and
3. the **Member** for whom the treatment is proposed
   a. is under seven years of age, or
   b. is developmentally disabled, regardless of age, or
   c. has a health condition which makes the general anesthesia **Medically Necessary**, regardless of age.

Coverage does not include charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist.

All services and supplies are subject to **Pre-Authorization** by the **Plan**.

Copayments, Coinsurance and **Deductibles** listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

U. **Diabetes Treatment.**

Treatment, education for outpatient self management, and equipment and supplies are covered when **Medically Necessary.** Coverage includes, but is not limited to:

1. Diabetic daycare self management and education programs, provided by appropriately licensed participating **Health Care Professionals.** Training shall include self-management training, education, and medical nutrition therapy necessary to enable you to properly use the equipment, supplies, and medications prescribed or referred by your **Health Care Professional**.

2. Diabetic equipment, supplies and medications:

   a. Insulin,

   b. Prescriptive medications for the treatment of diabetes,

   c. Glucagon,

   d. Blood glucose monitors and blood glucose testing strips,

   e. Blood glucose monitors designed to assist the visually impaired,

   f. Insulin pumps and all related necessary supplies,

   g. Ketone urine testing strips,

   h. Lancets and lancet puncture devices,

   i. Pen delivery systems for the administration of insulin,

   j. Podiatric devices to prevent or treat diabetes-related complications,

   k. Insulin syringes,

   l. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Coverage under this **EOC** includes a Prescription Drug Rider. The medications and supplies listed in the Prescription Drug Rider will be covered under the Prescription Drug Rider. Copayments for these medications and supplies are shown on the Prescription Drug Rider.

Copayments, Coinsurance and **Deductibles** listed in the Schedule of Benefits will apply to services and supplies not covered under the Prescription Drug Rider, depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to or obtain supplies or equipment from a **Non-Participating Provider** (Tier 3).

V. **Phenylketonuria Benefit.**

In addition to coverage for the testing and treatment of Phenylketonuria (PKU), coverage for treatment of Phenylketonuria includes those formulas and special food products that are part of a diet prescribed by your attending **Provider** and managed by a **Health Care Professional** in consultation with a **Specialist** who specializes in metabolic disease to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. For purposes of this section, "special food product" means a food product that is prescribed by your attending **Provider** and used in place of normal food products used by the general population. "Special food product" does not include foods that are naturally low in protein, but may include a food product that is specially formulated to have less than one (1) gram of protein per serving.

Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

W. **Additional Benefits.**

- **Temporomandibular Joint Syndrome Services**. Coverage for the treatment for temporomandibular joint dysfunction shall include pre-authorized **Medically Necessary** procedures. **Medically Necessary** excludes dental procedures, including but not limited to, the extraction of teeth and orthodontic devices and splints.

  Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to a **Non-Participating Provider** (Tier 3).

- **Durable Medical Equipment Benefits**.

  Durable Medical Equipment will be provided when **Pre-Authorized** by the **Plan**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **Plan** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **EOC**. The **Plan** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the **Plan**.

  Instruction and appropriate services required for you to properly use the item, such as attachment or insertion, is also covered upon **Pre-Authorization** by the **Plan**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **Plan** that:

  1. it is needed due to a change in your physical condition; or
  2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

  All maintenance and repairs that result from a misuse or abuse are your responsibility.

  All services and supplies over $1,500 are subject to **Pre-Authorization** by the **Plan**.

  Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to or receive supplies or equipment from a **Non-Participating Provider** (Tier 3).

- **Hearing Aids and Audiological Exam.**

  The **Plan** will cover 50% of the cost of two hearing aids, up to a maximum amount of $2,000. You are limited to two (2) hearing aids every thirty-six (36) months. This benefit is the same for all Tiers. No **Pre-Authorization** is required, and you may access any licensed **Provider.**

  The **Plan** will cover audiological exams necessary to determine the need for hearing correction and hearing devices. Audiological exams include screening, audiological evaluation, typanometry and acoustic reflex.

- **Infertility Services.**

  Infertility Services are not covered under Tiers 2 and 3.

  1. The following **Infertility** services are covered without a **Referral** when rendered by a **Participating Provider.**

a. You may Directly Access Gynecologists or **Infertility Specialists** associated with your **PCP's** IPA or Medical Group for basic diagnosis and treatment **Infertility** services, including:

- The following services for female members
- initial evaluation;
- ultrasound of ovaries at the **Participating** radiology facility associated with your **PCP** or, if none is affiliated with your **PCP,** to any **Participating** radiology facility;
- post-coital test;
- hysterosalpingogram;
- endometrial biopsy; and
- hysteroscopy.

b. Semen analysis for a male **Member** with a **Referral** from his **PCP.**

c. If you do not conceive after receiving the services specified in Section 1.a above, or if your diagnosis suggests that there is no reasonable chance of pregnancy as a result of these services, you may be eligible to receive coverage for the following comprehensive **Infertility** services through a **Participating Infertility Specialist** upon **Pre-Authorization** by the **Plan:**

- Ovulation induction with bloodwork and ultrasound associated with administration of medication, subject to a maximum of six (6) cycles per lifetime (where lifetime is defined to include services provided under any plan or any other health insurance or health maintenance organization plan or services that were not covered by any plan);
- Artificial insemination (AID, AIH, IUI), subject to a maximum of six (6) cycles per lifetime (where lifetime is defined to include services provided under any plan or any other health insurance or health maintenance organization plan or services that were not covered by any plan); and
- **Infertility** surgery (diagnostic or therapeutic).
- **Injectable Infertility Drugs.** These include, and are subject to change by the **Plan** or an affiliate, urofollitropin, menotropin, human chronic gonadotropin, progesterone.

- **Private Duty Nursing .**

  Coverage is provided for the charges for private duty professional nursing services from a L.P.N. or R.N. for a **Member's** non-hospitalized acute-illness or injury. Private duty nursing care furnished for **Custodial Care** is not covered.

  Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits will apply depending upon whether you access a **Participating Provider** with **PCP Referral** (Tier 1), **Self-Refer** to a **Participating Provider** (Tier 2), or **Self Refer** to or receive supplies or equipment from a **Non-Participating Provider** (Tier 3).

  All services and supplies are subject to **Pre-Authorization** by the **Plan**.

- **Acupuncture Services.**

  Coverage for acupuncture services is provided by American Specialty Health Plans. See Part IV of this booklet for information regarding coverage for acupuncture benefits.

- **Christian Science Practitioners and Sanatoriums**

  Under Tier 3, coverage will be provided for services provided by Christian Science practitioners accredited by the Mother Church, the First Church of Christ, Scientist in Boston Massachusetts, under the same terms and conditions as if such services had been provided by a **Health Professional.** Coverage will also be provided under Tier 3 for inpatient care provided in a Christian Science Sanatorium currently maintained by the Mother Church, First Church of Christ, Scientist, in Boston, Massachusetts, under the same terms and conditions as other inpatient care.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **EOC** or by a rider attached to this **EOC**:

1. Ambulance services, for routine transportation to receive outpatient or inpatient services.
2. Beam neurologic testing.
3. Biofeedback, except as specifically approved by the **Plan**.
4. Blood and blood plasma replaced by or for the patient, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
5. Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.
6. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
7. Charges costs associated with completion of a claim form.
8. Charges, expenses, or costs in excess of the **Reasonable Charge**.
9. Charges, expenses or costs applied toward satisfaction of any applicable **Deductible, Coinsurance, or Copayment** amounts and, under Tier 3, any penalty for not obtaining required **Pre-Authorization**.
10. Christian Science practitioner treatment through the use of communications media (including telephone consultations) or group treatment is not covered, nor is confinement for spiritual refreshment or any other service except as listed in the Covered Benefits section of this **EOC**.
11. **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Reconstructive Surgery**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary Reconstructive Surgery** by an **Appropriately Qualified Plan** Medical Director is not covered. This exclusion does not apply to surgery to correct the results of injuries or as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
12. Court ordered services, or those required by court order as a condition of parole or probation.
13. **Custodial Care**.
14. Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, including but not limited to, apicoectomy (dental root resection), orthodontics, root

canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, prosthetic restoration of dental implants, and dental implants. This exclusion does not include the removal of bony impacted teeth, bone fractures, removal of tumors, orthodontogenic cysts, and care or treatment to sound natural teeth necessary due to accidental injury for 12 months following the date of such injury, or care or treatment necessary due to congenital disease or anomaly.

15. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

16. **Experimental** or **Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by the **Plan**, unless approved by the **Plan** prior to the treatment being rendered.

    This exclusion will not apply with respect to drugs:

    a. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;

    b. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or

    c. the **Plan** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

17. False teeth.

18. Hair analysis.

19. Health services, including those related to pregnancy, rendered before the effective date or after the termination of your coverage, unless coverage is continued under COBRA, California Continuation or the Conversion section of this **EOC**.

20. Home births.

21. Home uterine activity monitoring.

22. Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments to vehicles.

23. Hypnotherapy, except when specifically approved by the **Plan**.

24. Implantable drugs, except Norplant.

25. **Infertility** services, except as provided in the Covered Benefits section of this **EOC** or by amendment or rider. This exclusion includes, but is not limited to:

    a. services for couples in which one of the partners has had a previous sterilization procedure with or without surgical reversal and for females who have undergone a hysterectomy;

    b. females with FSH levels greater than nineteen (19) mIU/ml on Day three (3) of the menstrual cycle;

    c. the purchase of donor sperm and any charges for the storage of sperm;

d. the purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

e. charges associated with cryopreservation or storage of cryopreserved embryos (i.e., office, **Hospital**, ultrasounds, laboratory tests, etc.);

f. Artificial insemination for females without male partners attempting to become pregnant who have not had at least twelve (12) cycles of donor insemination (six (6) cycles if the **Member** is age thirty-five (35) or older) prior to enrolling in the **Plan's Infertility** program;

g. any new technology used in an **Experimental or Investigational** program;

h. any service provided by a non-participating **Provider** or, in the case of comprehensive **Infertility** services, without a prior **Referral** or claim authorization from the **Plan's Infertility** program case management unit;

i. home ovulation prediction kits;

j. drugs related to the treatment of non-**Covered Benefits** or related to the treatment of **Infertility** that are not **Medically Necessary**,

k. any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to, in vitro fertilization (IVF), gamete intrafollopian tube transfer (GIFT), zygote intrafollopian tube transfer (ZIFT), and intractyplasmic sperm injection (ICSA);

l. any charges associated with care required for ART (i.e., office, **Hospital**, ultrasounds, laboratory tests, etc.);

m. donor egg retrieval or fees associated with donor egg programs including laboratory tests;

n. any charge associated with a frozen embryo transfer including thawing charges;

o. reversal of sterilization surgery; and

p. any charges associated with obtaining sperm for ART procedures.

26. Military service related diseases, disabilities or injuries for which you are legally entitled to receive treatment at government facilities and which facilities are reasonably available to you.

27. Missed appointment charges, including any charge incurred for a missed appointment with a **Provider**.

28. Non-**Medically Necessary** services, including but not limited to, those services and supplies:

a. which are not **Medically Necessary**, as determined by the **Plan**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

b. that do not require the technical skills of a medical, mental health or a dental professional;

c. furnished mainly for your personal comfort or convenience, or any person who cares for you, or any person who is part of your family, or any **Provider**;

d. furnished solely because you are an inpatient on any day in which your disease or injury could safely and adequately be diagnosed or treated while not confined;

e. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

29. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).

30. Orthopedic shoes or other supportive devices of the feet, except special footwear needed by a **Member** with bony abnormalities and deformities with significant disfigurement preventing the use of conventional standard foot gear in cases of cerebral palsy, arthritis, polio, diabetes, traumatic injuries, and congenital deformities.

31. Outpatient prescription or non-prescription drugs and medicines, except as specifically covered under the Prescription Drug section.

32. Outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.

33. Payment for benefits for which Medicare or a third party payer is the primary payer.

34. Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.

35. Private duty or special nursing care, unless **Pre-Authorized** by the **Plan**.

36. Radial keratotomy, including related procedures designed to surgically correct refractive errors.

37. Recreational, educational, and sleep therapy, including any related diagnostic testing.

38. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

39. Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

40. Routine foot/hand care, including routine reduction of nails, calluses and corns.

41. Services for which you are not legally obligated to pay in the absence of this coverage**.**

42. Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

43. Services performed by your relative for which, in the absence of any health benefits coverage, no charge would be made.

44. Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

45. Services which are not a **Covered Benefit** under this **EOC**, even when a prior **Referral** has been issued by a **PCP**.

46. Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

47. Specific injectable drugs, including:

    a. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);

    b. needles, syringes and other injectable aids except for treatment of diabetes;

    c. drugs related to the treatment of non-covered services; and

d. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids, except as described in this **EOC** or Prescription Drug Rider, such as performance enhancing steroids.

48. Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

49. Surgical operations, procedures or treatment of obesity, except when specifically approved by the **Plan**.

50. Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.

51. Thermograms and thermography.

52. Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

53. Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

54. Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **EOC**.

55. Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If you are covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

56. Vision care services and supplies, except as provided in the Covered Benefits section of this **EOC** or by rider to this **EOC**.

57. Weight reduction programs, or dietary supplements**.**

58. Coverage of a non-**Member** donor in a transplant procedure unless the recipient of the transplant is a **Member**. In the event a **Plan Member** is the recipient, coverage will be provided under this **EOC** for a non-**Member** donor to the extent benefits are unavailable from any other source.

59. Temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section.

B. **Limitations.**

1. In the event there are two or more alternative **Medical Services** which in the sole judgment of the **Plan** are equivalent in quality of care, the **Plan** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by the **Plan**, provided that the **Plan** approves coverage for the **Medical Service** or treatment in advance.

2. Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **EOC** are at the sole discretion of the **Plan,** subject to the terms of this **EOC**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE PLAN NETWORK ARE AT THE SOLE DISCRETION OF THE PLAN.

TERMINATION OF COVERAGE

A **Member's** coverage under this **EOC** will automatically terminate upon the earliest of any of the conditions listed in the Termination of Coverage section of Part I, page 6. Coverage may also terminate for the reasons listed below.

A. **Termination of Subscriber Coverage.**

A **Subscriber's** coverage will terminate for any of the following reasons:

1. employment terminates;
2. the **Group Agreement** terminates;
3. the **Subscriber** is no longer eligible as outlined in Termination of Coverage section of Part I, page 6; or
4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **EOC**.

B. **Termination of Dependent Coverage.**

A **Covered Dependent's** coverage will terminate for any of the following reasons:

1. a **Covered Dependent** is no longer eligible, as outlined in the Termination of Coverage section of Part I, page 6;
2. the **Group Agreement** terminates; or
3. the **Subscriber's** coverage terminates;

C. **Member Termination For Cause.**

The **Plan** may terminate coverage for cause:

1. subject to the **Grievance** Procedure described in this **EOC,** upon thirty-one (31) days advance written notice, if the **Member** is unable to establish or maintain, after repeated attempts, a satisfactory **Physician**-patient relationship with a **Participating Provider**. Notice shall be given by certified mail and return receipt requested. At the effective date of such termination, prepayments received by the **Plan** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to the **Contract Holder**.
2. upon thirty-one (31) days advance written notice, if the **Member** has failed to make any required **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by the **Plan** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.

D. **Disenrollment by Member.**

If you elect coverage under an alternative health benefits plan offered by or through **Contract Holder** as an option to coverage under the **Plan,** your coverage terminates automatically at the time and date the alternate coverage becomes effective. You and **Contract Holder** agree to notify the **Plan** immediately that coverage has been elected elsewhere.

You may voluntarily disenroll from the **Plan** at any time and for any reason. You may disenroll by notifying the **Contract Holder** and/or the **Plan** in writing of your intent to cancel **Membership**. Your coverage terminates at midnight on the last day of the month during which **Premiums** are taken from earnings based on an eligible appointment.

E. **Effective Date of Termination.**

Coverage as a **Member** ceases on the earlier of the following dates:

1. At midnight on the last day of the month in which the **Member** was eligible and for which monthly payment has been received.

2. At midnight on the termination date specified in the notice of cancellation;

3. On the termination date established by the **Plan** and **Contract Holder** as specified in the **Group Agreement** or as otherwise agreed by **Contract Holder**.

The **Plan** shall have no further liability or responsibility under this **EOC** except for coverage for **Covered Benefits** provided prior to the date of termination of coverage.

The fact that **Members** are not notified by the **Contract Holder** of the termination of their coverage due to the termination of the **Group Agreement** shall not deem the continuation of a **Members'** coverage beyond the date coverage terminates.

F. **Member's Right to Review.**

You may request that the **Plan** conduct a **Grievance** hearing, as described in the **Grievance** Procedure section of this **EOC**, within fifteen (15) working days after receiving notice that the **Plan** has or will terminate your coverage as described in the Termination For Cause subsection of this **EOC** and in the Termination of Coverage section of Part I, page 6. The **Plan** will continue your coverage in force until a final decision on the **Grievance** is rendered, provided the **Premium** is paid throughout the period prior to the issuance of that final decision. The **Plan** may rescind coverage, to the date coverage would have terminated had the **Member** not requested a **Grievance** hearing, if the final decision is in favor of the **Plan**. If coverage is rescinded, the **Plan** will refund any **Premiums** paid for that period after the termination date, minus the cost of **Covered Benefits** provided to a **Member** during this period.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **EOC's Grievance** Procedure to register a complaint against the **Plan**. If you believe your membership was terminated because of your health status or requirements for health care services, you may request a review by the Commissioner of the California Department of Managed Health Care.

CONTINUATION AND CONVERSION

Members with questions concerning HIPAA may contact the Health Care Financing Administration (HCFA) at the following telephone number [1-415-744-3600]. HCFA has posted at its web site a publication entitled: "Commonly Asked Questions and Answers for Consumers about the Provisions of Health Insurance Portability and Accountability Act of 1996" at the following Internet address: [http://www.hcfa.gov/regs/hipaacer.htm]. HCFA may be contacted directly, by mail, at : Health Care Financing Administration, Attention: HIPAA Unit, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105.

A. **Continued Group Coverage (COBRA and California Continuation Care).**

Please see the Optional Continuation of Coverage section on of Part I, page 7 for additional information about your rights to COBRA and California Continuation Coverage.

B. **Extension of Benefits Upon Total Disability.**

Any **Member** who is **Totally Disabled** on the date coverage under this **EOC** terminates due to the termination of the contract between **HMO** and **Contract Holder** is covered in accordance with the **EOC**.

This extension of benefits shall only:

1. provide **Covered Benefits** that are necessary to treat medical conditions causing or directly related to the disability as determined by **HMO**; and

2. remain in effect until the earlier of the date that:

   a. the **Member** is no longer **Totally Disabled**; or

   b. the **Member** has exhausted the **Covered Benefits** available for treatment of that condition; or

c. the **Member** has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or

d. after a period of twelve (12) months in which benefits under such coverage are provided to the **Member**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

C. **Conversion Privilege.**

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by the **Plan**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Plan** will give notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the Optional Continuation of Coverage section of Part I, page 7, the **Plan** will notify the **Member** at some time during the one hundred eighty (180)-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **EOC** and has been continuously enrolled for three (3) months under any plan offered by the **Contract Holder**, such person may, within thirty-one (31) days after termination of coverage under this **EOC**, convert to individual coverage with the **Plan**, effective as of the date of such termination, without evidence of insurability provided that **Member's** coverage under this **EOC** terminated for one of the following reasons:

a. Coverage under this **EOC** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder**; or

b. The **Subscriber** ceased to meet the eligibility requirements (other than retirement) as described in the Eligibility and Enrollment section of this **EOC** and under the Eligibility section of Part I, page 1, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **EOC**, if any, are eligible to convert; or

c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **EOC** because of the **Member's** age or death or divorce of **Subscriber**; or

d. Continuation coverage ceased under any Continuation Coverage section of this **EOC**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as the **Plan** may have in effect at the time of **Member's** application for conversion, without furnishing evidence of insurability. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, the **Plan** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

GRIEVANCE PROCEDURE

A. **Member's Right To Independent Medical Review.**

Beginning January 1, 2001, **Members** have the right to an independent medical review of decisions by the **Plan** to deny, modify or delay coverage for health care service(s) based on **Medical Necessity (Disputed Health Care Services)**. Beginning January 1, 2000 **Members** have the right to an independent medical review of decisions by the **Plan** to deny coverage for a health care service because that service has been determined by the **Plan** to be **Experimental and Investigative**. The Department of Managed Health Care will manage the independent medical review process which is available to you when you meet the criteria developed by the Department of Managed Health Care. You are not required to pay any application or processing fees to request or receive independent medical review. Independent medical review is available in addition to the **Plan Grievance** procedures and any other remedies available to you by law. You should be aware that a decision not to participate in the independent medical review process may cause you to forfeit any statutory right to pursue legal action against the **Plan** regarding the **Disputed Health Service.** Please consult the "Special Grievance Procedure for Expedited Review", the "Special Grievance Procedure for Experimental Treatment" and the "Special Grievance Procedure for **Disputed Health Care Services**" sections below for additional information on how you may exercise your right to independent medical review.

B. **Grievance Review.**

The following procedures govern complaints, **Grievances**, and **Grievance** appeals made or submitted by **Members** to the **Plan**. When you submit a **Grievance** to the **Plan** either in writing or by telephone through Member Services:

1. A written notice shall be sent to you by the **Plan:**
    a. acknowledging each **Grievance**;
    b. inviting you to provide any additional information to assist the **Plan** in handling and deciding the **Grievance**;
    c. informing you of your right to have an uninvolved **Plan** representative assist you in understanding the **Grievance** process;
    d. informing you as to when a response to your **Grievance** should be forthcoming; and
    e. informing you of your right to independent medical review if your **Grievance** is regarding a **Disputed Health Care Service**, or services which have been determined by the **Plan** to by **Experimental or Investigational Procedures.**
2. The Grievance Coordinator shall not be any person who made the initial decision regarding the claim, or any person with previous involvement with the **Grievance**. The **Plan** shall review and decide the **Grievance** within thirty (30) days of receipt or longer by mutual written agreement between you and the **Plan**.
3. A written notice stating the result of the review by the **Plan** shall be forwarded to you by the **Plan**. Such notice shall include:
    a. a description of the Coordinator's understanding of your **Grievance** as presented to the Grievance Coordinator (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and
    b. the **Plan**'**s** decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for you to respond further to the **Plan's** position (e.g., you did not contact the **PCP**, the services were non-**Emergency Service**s as identified in the medical report, the services were not covered by the **EOC**, etc.); and
    c. citations to the evidence or documentation used as the basis for the decision (i.e., reference to the **EOC**, medical records, etc.); and

d. for **Grievance**s where the denial is a **Coverage Decision**, the notice will clearly specify the provisions in the **EOC** that exclude that coverage, or

e. for **Grievance**s where the denial is of a **Disputed Health Care Service,** the notice will describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to **Medical Necessity**; and

f. a statement indicating:

i. that the decision of the **Plan** will be final and binding unless you appeal in writing to the Grievance Appeal Committee within thirty (30) days of the date of the notice of the decision of the Grievance Coordinator whenever possible, and

ii. a description of the process of how to appeal to the Grievance Appeal Committee.

iii. In the case of a **Disputed Health Care Service**, the notice shall also contain an explanation of your right to independent medical review and the forms and instructions necessary to request independent medical review.

C. **Appeal Hearing.**

1. Upon receipt of a written appeal by the Grievance Appeal Committee, the **Plan** shall provide you with the procedures governing appeals before the Grievance Appeal Committee. You shall be notified of your right to have an uninvolved **Plan** representative available to assist you in understanding the appeal process.

2. The Grievance Appeal Committee shall be established by the Board of Directors of the **Plan** and shall be comprised of three members, one of whom shall be a non-employee **Subscriber** of the **Plan**. The Grievance Appeal Committee shall not include any person previously involved with the **Grievance**. A **Plan** Medical Director may serve as a member of the Committee if the Medical Director was not previously involved with the **Grievance**.

3. The Grievance Appeal Committee shall hold appeal hearings in the **Plan** offices on scheduled days each month to consider all appeals filed seven business days or more in advance of the hearing day. In the event you are unable to attend the hearing on the scheduled hearing day, you may request that your appeal be heard on the next scheduled hearing day.

4. You have the right to attend the appeal hearing and present your case. You also have the right to be assisted or represented by a person of your choice, and submit written material in support of your **Grievance**. You may bring a **Physician** or other expert(s) to testify on your behalf. The **Plan** shall also have the right to present witnesses. You may have your Attorney present your case and question witnesses. If you are so represented, the **Plan** may be similarly represented by Counsel. The Grievance Appeal Committee shall have the right to question you, the **Plan** representative, and any other witnesses.

5. The appeal hearing shall be informal. That is, the Grievance Appeal Committee shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Grievance Appeal Committee shall have the right to exclude redundant testimony or excessive argument by any party or witness.

6. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Grievance Appeal Committee shall ask both you (or your counsel) and the **Plan** representative whether there is any additional evidence or argument which either party wishes to present to the Grievance Appeal Committee. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Grievance Appeal Committee shall be confidential and shall not be transcribed.

8. The Grievance Appeal Committee shall render a written decision within thirty (30) working days of the conclusion of the appeal hearing whenever possible. The decision shall contain:

   a. a statement of the Grievance Appeal Committee's understanding of the nature of the **Grievance** and the material facts related thereto; and

   b. the Grievance Appeal Committee's decision and rationale; and

   c. a summary of the evidence, including necessary document supporting the decision; and

   d. when applicable, a statement of your right to appeal to the Department of Managed Health Care, including the phone number and complete address of the Department of Managed Health Care and your right to independent medical review with the forms and instructions necessary to request the independent medical review.

D. **Special Grievance Procedure for Expedited Review.**

1. In the event a **Grievance** involves imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, you will receive expedited review of your **Grievance**. Either the Department of Managed Health Care or the **Plan** may decide that a **Grievance** requires expedited review.

2. When the **Plan** receives a **Grievance** requiring expedited review the **Plan** will immediately inform you in writing of your right to notify the Department of Managed Health Care of the **Grievance**.

3. A **Plan** Medical Director shall review the matter and make a determination within seventy-two (72) hours of receipt.

4. The decision of the Medical Director shall be provided to you by telephone and confirmed in writing.

5. The **Plan** will provide to you and the Department of Managed Health Care a written statement on the disposition or pending status of the **Grievance** no later than three (3) days from the receipt of the **Grievance**.

E. **Special Grievance Procedure for Experimental and Investigative Procedures.**

Members have the right to request an independent medical review when coverage is denied as an **Experimental or Investigational Procedure** when the following conditions are met:

1. You have a **Life-Threatening** or **Serious Debilitating Illness** ; and

2. Your **Physician** certifies that you have a condition, described in (1) above, for which

   a. standard therapies have not been effective in improving your condition, or

   b. standard therapies would not be medically appropriate, or

   c. there is no more beneficial standard therapy covered by the plan than the therapy proposed in by the **Physician**, and

3. your **Participating Physician** has certified in writing that the proposed procedure, device, drug or other therapy is more likely to be more beneficial to you than any available standard therapies, **or**

4. you**,** or your Physician (who is a licensed, board-certified or board-eligible **Physician**, qualified to practice in the area of practice appropriate to treat your condition) has provided to the **Plan** a written statement which certifies that, based on two documents from **Medical and Scientific Evidence** the requested, drug, device, procedure or therapy is likely to be more beneficial to you than any available standard therapy. You or your **Physician** must identify the documents relied upon as **Medical and Scientific Evidence** as part of the written certification.

When coverage for a requested service is denied as **Experimental and Investigative,** the **Plan** must notify you in writing, within five (5) business days of the date of the decision to deny coverage, of your right to

request independent medical review. Included with the notice will be the forms and instructions necessary to apply to the Department of Managed Health Care. You will need demonstrate to the Department of Managed Health Care that you meet criteria (1), (2) and (3), or criteria (1), and (4).

You may request an independent medical review, within thirty (30) days of the receipt of the notice of the denial. The independent medical review will be to review the specific medical and scientific reasons for the denial of the coverage. The review will be done at no cost to you. The Department of Managed Health Care will evaluate your request and decide whether your **Grievance** qualifies for independent medical review and notify you and the **Plan** of its decision. Within five (5) business days of notification from the Department of Managed Health Care that your request for independent medical review has been approved, the **Plan** must provide the independent entity performing the review with the medical records relevant to your condition, a copy of the relevant documents used by the **Plan** in determining whether the proposed therapy is covered, and any other information submitted to the **Plan** by you or your **Physician** in support of the request for coverage.

If your **Participating Provider** determines, after consultation with the **Plan's** Medical Director, that, based on standard medical practice, the effectiveness of either the proposed treatment or any alternative treatment covered under this **EOC** would be materially reduced if not provided at the earliest possible date, the review shall be done within seven (7) business days of the date of the request, and the **Plan** shall submit the above referenced documents within one (1) business day of the Department of Managed Health Care's notification to the **Plan** that your **Grievance** qualifies for independent medical review.

F. **Special Grievance Procedure for Disputed Health Care Services Effective January 1, 2001.**

As part of the **Grievance** process, you have the right to an independent medical review of your **Grievance**, when you believe that health care services have been improperly denied, modified, or delayed because they are not **Medically Necessary** (**Disputed Health Care Service),** and the conditions listed below are met.

1. You have filed a **Grievance** with the **Plan** regarding the **Disputed Health Care Service.**
2. You have participated in the **Plan's Grievance** process for thirty (30) days, except in cases where your **Grievance** requires expedited review, or the **Plan** has responded to your **Grievance** by upholding the **Plan's** denial of the **Disputed Health Care Service**.
3. Either, your **Provider** must have recommended the health care service as **Medically Necessary**; or you received **Urgent Care** or **Emergency Services** that a **Provider** deemed **Medically Necessary,**
4. Or, you have received or wish to receive the **Disputed Health Care Service** from a properly accessed **Participating Provider**, whether or not the **Participating Provider** recommended the **Disputed Health Care Service.**

Members may request an independent medical review for services recommended or performed by a **Non-Participating Provider, <u>but the Plan has no liability to pay for the services of a Non-Participating Provider unless you have been referred to the Non-Participating Provider according to the requirements set forth in this EOC</u>.**

The **Plan** will respond to your initial **Grievance** regarding a **Disputed Health Care Service** as described in the section "Grievance Review". If the **Plan's** decision is to uphold the its initial utilization management decision to deny, modify or delay coverage for the **Disputed Health Care Service,** the notice to you will include:

1. a description of the criteria and clinical reasons for the decision, including all criteria and clinical reasons related to **Medical Necessity**;
2. a one page application form, instructions and an envelope addressed to the Department of Managed Health Care which you may use to request independent medical review. The form will contain:
    a. any information required by the Department of Managed Health Care to facilitate the completion of the independent medical review;

b. notice to you that a decision not to participate in the independent medical review process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the **Disputed Health Care Service**;

c. a statement indicating your consent to obtain any necessary medical records from the **Plan**, any of its **Participating Providers,** and any **Non-Participating Provider** you may have consulted, to be signed by you**;** and

d. notice of your right to provide information or documentation, either directly or through your **Provider** as required by H&S § 1374.30(A), (B), and (C).

When the **Plan** receives notice from the Department of Managed Health Care approving your request for an independent medical review, the **Plan** will submit the documents required by H&S 1374.30(n) within three (3) business days.

The **Plan** will concurrently provide a copy of these documents to you and your **Provider.**

In the event of the imminent and serious threat to your health, the **Plan** will deliver the required documents to the Independent Medical Review Organization within one (1) business day of notification from the Department of Managed Health Care of its approval of your request.

G. **Department of Managed Health Care and Independent Medical Review.**

If you decide to pursue independent medical review during the **Plan** grievance process, you should complete the form which you will have received from the **Plan** and send it to the Department of Managed Health Care in the envelope which you will have received with the forms and instructions. The Department will review your request and determine whether you meet the criteria for independent medical review of a **Disputed Health Care Service**, and therefore qualify for an independent medical review of your **Grievance**. If the Department of Managed Health Care approves your request for independent medical review, your **Grievance** will be submitted to a medical specialist or a panel of specialists from the Independent Medical Review Organization. The designated specialist(s) will make an independent determination of whether or not the care which is the subject of the **Grievance** is medically necessary or does not qualify for exclusion as an **Experimental or Investigative Procedure.** You will receive a copy of the independent medical review assessment of your **Grievance.** If the decision of the independent medical review is that the care is medically necessary or does not qualify as an **Experimental or Investigative Procedure**, the **Plan** will cover the provision of the health care services which were the subject of the **Grievance.**

For non-urgent cases the, the independent medical review organization must provide its determination within thirty (30) days of receiving your application and supporting documents. For cases which qualify for expedited review, the independent medical review organization must provide its determination within three (3) business days.

For more information regarding the independent medical review process, or to request an application form, please call the **Plan** Member Services Department at 1-800-313-3804.

H. **Exhaustion of Process.**

The foregoing procedures and processes are mandatory and must be exhausted prior to the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **EOC** by the **Plan**, or any matter within the scope of the **Grievance** resolution process of any complaint, **Grievance** or **Grievance** appeal.

I. **Record Retention.**

The **Plan** shall retain the records of all **Grievances** for a period of at least seven (7) years.

J. **Fees and Costs.**

Nothing herein shall be construed to require the **Plan** to pay counsel fees or any other fees or costs incurred by you in pursuing a **Grievance** or appeal.

K. **Review by Governmental Agencies.**

At any time during the Inquiry and **Grievance** Procedure above, you have the right to submit unresolved **Grievances** and complaints to the California Department of Managed Health Care for review.

The following is a notice that the Plan is required to provide to Members that tells how to contact the Plan and the Department of Managed Health Care.

"The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number 1-888-HMO-2219 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.hmohelp.ca.gov) has complaint forms and instructions online.

If you have a grievance against your health plan, you should first telephone your plan at 1-800-313-3804 and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unsolved for more than thirty (30) days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law."

The Department of Managed Health Care should be contacted only after discussions with the **Plan,** or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

The **Plan** toll-free telephone number is: 1-800-313-3804.

The addresses of the **Plan** is:

Aetna U.S. Healthcare of California Inc.
P.O. Box 54280
Los Angeles, CA 90054-0280

The Department of Managed Health Care should be contacted only after discussions with the **Plan,** or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

L. **Request for Binding Arbitration.**

If you do not agree with the **Plan's** final determination, you may, within sixty (60) days of the **Plan's** written notice of its final determination, initiate binding arbitration as described in the following section.

BINDING ARBITRATION

Binding arbitration is the final process for resolving any disputes between Interested Parties arising from or related to the **Plan's** coverage, whether stated in tort, contract or otherwise. This includes (but is not limited to) disputes involving alleged professional liability or medical malpractice (that is, whether any **Medical Services** were unnecessary or unauthorized or were improperly, negligently or incompetently rendered). Interested Parties are **Contract Holder, Members**, the heirs-at-law or personal representative(s) of a **Member**, a **Participating Provider** and the **Plan**, including any affiliates agents, employees or subcontractors of an Interested Party. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter. All Interested Parties are giving up their constitutional right to have their dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that Interested Parties will not be able to try their case in court.

Unless otherwise agreed by the parties to the arbitration, all disputes shall be submitted to neutral arbitration within the **Plan's** Service Area in accordance with the Commercial Rules of the American Arbitration Association (AAA) or such other neutral dispute resolution organization as mutually agreed by the parties. The AAA can be reached by calling 1-213-383-6516 (Los Angeles), 1-415-981-3901 (San Francisco), or 1-619-239-3051 (San Diego). If the AAA declines the case and the parties do not agree on an alternative organization, then a neutral arbitrator shall be appointed upon petition to the court under California Code of Civil Procedure Section 1281.6. The arbitration shall

occur in the **Member's** choice of Los Angeles, San Francisco, or San Diego unless otherwise agreed or determined by the arbitrator.

The parties will share equally the arbitrator's fee, if any, as well as any administrative fee, unless otherwise assessed by the arbitrator. In cases of extreme hardship to a **Member**, the **Member** may request at any time that the arbitrator or dispute resolution organization may allocate all or a portion of the **Member's** share of the arbitrator's fees and expenses to the **Plan**. For more information regarding this arbitration process, please call the **Plan's** phone number located on the **Member's** ID card.

The arbitrator will establish the procedures which will govern the arbitration, including procedures concerning discovery. The arbitrator is bound by applicable state and federal law and regulations and shall issue a written opinion setting forth findings of fact, conclusions of law and the basis of the decision. The arbitrator is authorized to award equitable as well as legal relief to the extent permitted by law. The parties expressly agree and covenant to be bound by the decision of the arbitrator as a final determination of the matter in dispute, subject only to such grounds as are available to challenge an arbitration decision under California law. This arbitration provision is subject to enforcement and interpretation under the Federal Arbitration Act.

LIMITATIONS ON REMEDIES

A. **No Jury Trial**

In any dispute arising from or related to the **Plan** coverage, there shall be no right to a jury trial. The right to trial by a jury is expressly waived.

B. **Medical Malpractice Claims**

Any claim alleging wrongful acts or omissions of **Participating Providers** shall not include the **Plan** and shall include only **Participating Providers** subject to the allegation. **Members** waive their right to bring any such claim against the **Plan** as a party in any such claim.

C. **Punitive Damages**

Any award of punitive damages must be authorized by and recoverable under all applicable law, be based upon clear and convincing evidence of outrageous conduct by the **Plan**, and bear reasonable relationship to actual recoverable damages. No punitive damages related to the denial or the reduction of benefits or payment shall be recoverable where the **Member** has not pursued external independent medical review where available, the external reviewer(s) has confirmed the **Plan's** decision, or the **Plan** has abided by the decision of the external reviewer(s).

D. **Class Actions**

No **Member** may participate in a representative capacity or as a member of any class of claimants in any proceeding arising from or related to the **Plan** coverage. Claims brought by any **Member** (including his/her **Covered Dependents**) may not be joined or consolidated with claims brought by any other **Member(s)** unless otherwise agreed to in writing by the **Plan.** Any right to participate in a class or in a representative capacity, or to join or consolidate claims with other parties, is expressly waived.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **EOC**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **EOC**, including any applicable benefits payable for dental or pharmacy services or supplies.

When coverage under this **EOC** and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

B. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

1. secondary to the plan covering the person as a dependent; and

2. primary to the plan covering the person as other than a dependent;

the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

1. covers the person as other than a dependent; and

2. is secondary to Medicare.

C. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:

1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.

2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

3. If there is not such a court decree:

   If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

   If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

E. If A, B, C and D above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or

2. the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or

2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and

2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The **Plan** has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

Other plan means any other plan of health expense coverage under:

1. Group insurance.

2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, the **Plan** will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **EOC** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **EOC**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **EOC**. If it does, the **Plan** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by the **Plan**. The **Plan** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

If the benefits paid under this **EOC**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, the **Plan** has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at the **Plan 's** discretion. A **Member** shall execute any documents and cooperate with the **Plan** to secure its right to recover such overpayments, upon request from the **Plan**.

Medicare And Other Federal Or State Government Programs.

The provisions of this section will apply to the maximum extent permitted by federal or state law. the **Plan** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that the **Plan** determine its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **EOC** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **EOC** shall be payable to and retained by the **Plan**. Each **Member** shall complete and submit to the **Plan** such consents, releases, assignments and other documents as may be requested by the **Plan** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

Active Employees and Their Dependents Who Are Eligible For Medicare.

Certain rules apply to active employees and their **Covered Dependents** who are eligible for Medicare. When an active **Subscriber,** or the **Covered Dependent** of an active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent** belongs to a group covered by this **EOC** with twenty (20) or more employees the coverage under this **EOC** will be primary. If the **Member** belongs to a covered group of less than twenty (20) employees, Medicare benefits will be primary and benefits payable under this **EOC** will be terminated.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **EOC** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Medicare Members and Coordination of Benefits.

The **Plan** reserves the right to figure the total amount of "regular benefits" for any medical benefits under this **EOC**. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, the **Plan** will pay the difference. Otherwise, the **Plan** will pay no benefits. This will be done for each claim throughout the calendar year. Charges for services used to satisfy a **Member's** Medicare Part B deductible will be applied under this **EOC** in the order received by the **Plan**. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for **Coordination of Benefits**, as outlined in this **EOC**, will be applied after the **Plan's** benefits have been calculated under the rules in this section. **Covered Benefits** will be reduced by any Medicare benefits available for those expenses.

THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

If the **Plan** provides health care benefits under this **EOC** to a **Member** for injuries or illness for which a third party is or may be responsible, then the **Plan** retains the right to repayment of the full cost of all benefits provided by the **Plan** on behalf of the **Member** that are associated with the injury or illness for which the third party is or may be responsible. the **Plan's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a **Member** for injuries resulting from alleged negligence of a third party.

The **Member** also specifically acknowledges the **Plan's** right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the **Plan** has provided health care benefits for injuries or illness for which a third party is or may be responsible and the **Member** and/or the **Member's** representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this **EOC**, the **Plan** is granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by the **Plan**.

The **Member** and the **Member's** representatives further agree to:

A. Notify the **Plan** promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the **Member** that may be the legal responsibility of a third party; and

B. Cooperate with the **Plan** and do whatever is necessary to secure the **Plan's** rights of reimbursement under this **EOC**; and

C. Give the **Plan** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by the **Plan** for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due the **Plan** as reimbursement for the full cost of all benefits associated with injuries or illness provided by the **Plan** for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by the **Plan** in writing; and

E. Do nothing to prejudice the **Plan's** rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by the **Plan**.

The **Plan** may recover the full cost of all benefits provided by the **Plan** under this **EOC** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the **Plan's** recovery without the prior express written consent of the **Plan**. In the event the **Member** or the **Member's** representative fails to cooperate with the **Plan**, the **Member** shall be responsible for all benefits paid by the **Plan** in addition to costs and attorney's fees incurred by the **Plan** in obtaining repayment.

RESPONSIBILITY OF MEMBERS

A. You shall complete and submit to the **Plan** such application or other forms or statements as the **Plan** may reasonably request. You represent that all information contained in such applications, forms and statements submitted to the **Plan** incident to enrollment under this **EOC** or the administration herein shall be true, correct, and complete to the best of your knowledge and belief.

B. You shall notify the **Plan** immediately of any change of address for you or any of your **Covered Dependents**.

C. You understand that the **Plan** is acting in reliance upon all information provided to the **Plan** by you at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage under this **EOC**, or accepting benefits under this **EOC**, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. You are subject to and will abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by the **Plan** to **Members** pursuant to this **EOC** is for identification purposes only. Possession of a **Plan** identification card confers no right to services or benefits under this **EOC**, and misuse of such identification card may be grounds for termination of your coverage pursuant to the Termination of Coverage section of this **EOC**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **EOC**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **EOC** have been paid. Any person

receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **EOC** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's** identification card by any other person, such card may be retained by the **Plan**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **EOC** shall be terminated immediately, subject to the **Grievance** Procedure set forth in the **Grievance** Procedure section of this **EOC**.

B. **Reports and Records.** The **Plan** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **EOC** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **EOC**. By accepting coverage under this **EOC**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered under this EOC, authorizes each and every **Provider** who renders services to a **Member** covered by this **EOC** to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to the **Plan**, or a medical, dental, or mental health professional that the **Plan** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to the **Plan**, or a medical, dental, or mental health professional that the **Plan** may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the **Member's** records by the **Plan**.

C. **Refusal of Treatment.** You may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Provider**. If the **Provider** (after a second **Provider's** opinion, if requested by you) believes that no professionally acceptable alternative exists, and if after being so advised, you still refuse to follow the recommended treatment or procedure, neither the **Participating Provider**, nor the **Plan**, will have further responsibility to provide any of the benefits available under this **EOC** for treatment of such condition or its consequences or related conditions. The **Plan** will provide written notice to you of a decision not to provide further benefits for a particular condition. This decision is subject to the **Grievance** Procedure set forth in the **Grievance** Procedure section of this **EOC**. Coverage for treatment of the condition involved will be resumed in the event you agree to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits under this **EOC** are personal to the **Member** and may not be assigned.

E. **Legal Action.** No claim in law or in equity may be maintained against the **Plan** for any expense or bill prior to the expiration of sixty (60) days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**. No action shall be brought after the expiration of three (3) years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or **Non-Participating Provider**, institution, facility or agency is an agent or employee of the **Plan**. Neither the **Plan** nor any **Member** of the **Plan** is an agent or employee of any **Participating Provider** or **Non-Participating Provider**, institution, facility or agency. **Members** shall not include the **Plan** as a party in any legal proceeding alleging medical malpractice.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of the **Plan**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which the **Plan** has made or hereafter shall make arrangements for services under this **EOC**.

3. **Participating Physicians** and **Non-Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to the **Member** for all **Medical Services** which they provide.

4. The **Plan** cannot guarantee the continued participation of any **Provider** or facility with the **Plan**. In the event a **PCP** terminates its contract or is terminated by the **Plan**, the **Plan** shall provide notification to you in the following manner:

   a. within thirty (30) days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

   b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and five (5) business days after notification of the contract termination is mailed to you at your last known address shall continue to be **Covered Benefits**.

   If you are undergoing an **Active Course of Treatment** you may refer to the **EOC** Procedure section, "Requesting Continuity of Care", for information about how to continue treatment with a terminated **Participating Provider** for a limited time.

5. **Restriction on Choice of Providers:** Unless otherwise approved by the **Plan**, you must utilize **Participating Providers** and facilities who have contracted with the **Plan** to provide services in order for those services to be covered under Tier 1 or 2. For services covered under Tier 1, when you need a **Specialist,** your **PCP** will provide you with an authorized **Referral** to a **Participating Provider** within your **PCP's** associated medical group or IPA, unless it is **Medically Necessary** to refer you to a **Specialist** outside of the **PCP's** associated medical group or IPA or to a **Non-Participating Provider**. For certain services, your **PCP** must also obtain **Pre-Authorization** from the **Plan**.

G. **Medical Malpractice Claims.** In no event shall the **Plan** be liable for the negligence, wrongful acts or omissions of **Participating Providers** or **Non-Participating Providers**. ANY CLAIM ALLEGING SUCH NEGLIGENCE, WRONGFUL ACTS OR OMISSIONS (INCLUDING BUT NOT LIMITED TO MEDICAL MALPRACTICE) SHALL NOT INCLUDE THE **PLAN** AND SHALL INCLUDE ONLY THE **PROVIDERS** SUBJECT TO THE ALLEGATION. BY ENROLLING IN THIS PLAN, **MEMBERS** WAIVE THEIR RIGHT TO BRING ANY CLAIM AGAINST THE **PLAN**, OR TO JOIN AS A PARTY IN ANY SUCH CLAIM, REGARDING SUCH DISPUTES. You understand and acknowledge that the **Plan** and **Participating Providers** are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by this **Evidence of Coverage** or the **Group Agreement**.

H. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of the **Plan**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the rendition of medical or **Hospital** benefits or other services provided under this **EOC** is delayed or rendered impractical, the **Plan** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by the **Plan** on the date such event occurs. The **Plan** is required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

I. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the **Physician**-patient relationship or **Hospital**-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without your consent except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by the **Plan** in connection with the administration of this **EOC**, or in the compiling of aggregate statistical data.

J. **Incontestability.** In the absence of fraud, all statements made by you shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Group Agreement** has been in force for two (2) years from its effective date, unless the statement was material to the risk and was contained in a written application.

K.. This **EOC** applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, **Covered Benefits**.

L. **Contract Holder** hereby makes the **Plan** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **EOC**. However, this **EOC** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Managed Health Care. This can also be done by mutual written agreement between the **Plan** and **Contract Holder** without the consent of **Members**.

M. The **Plan** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **EOC**.

N. No agent or other person, except an authorized representative of the **Plan**, has authority to waive any condition or restriction of this **EOC**, to extend the time for making a payment, or to bind the **Plan** by making any promise or representation or by giving or receiving any information. No change in this **EOC** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of the **Plan**.

O. This **EOC**, including the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire **EOC** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **EOC** shall be binding unless executed in writing by authorized representatives of the parties.

P. This **EOC** has been entered into and shall be construed according to applicable state and federal law.

Q. The Public Policy Committee is a panel of representatives from employer groups, the **Plan Members,** the Board of Directors and the **Plan's** Medical Director. The committee meets on a quarterly basis to discuss policies and issues of concern to **Members**. For additional information about the committee, please direct inquiries to Member Services at the toll-free number shown on your ID Card.

R. **Proof of Loss and Claims Payment.**

1. **Proof of Loss:** Written proof of loss must be furnished to the **Plan** within ninety (90) days after a **Member** incurs **Covered Benefits**. Failure to furnish the proof of loss within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the proof of loss within ninety (90) days, provided the proof of loss is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the proof of loss may not be furnished later than one (1) year from the date when the proof of loss was originally required. A proof of loss form may be obtained from the **Plan** or the **Contract Holder**. If the **Member** does not receive such form before the expiration of fifteen (15) working days after the **Plan** receives the request, the **Member** shall be deemed to have complied with the requirements of this **EOC** upon submitting within the time fixed in this **EOC** written proof covering the occurrence, character and extent of the loss for which claim is made.

2. **Time for Payment of Claim:** Benefits payable under this **EOC** will be paid promptly after the receipt by the **Plan** of satisfactory proof of loss. If any portion of a claim is contested by the **Plan**, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss by the **Plan**.

3. **Payment of Claims:** All or any portion of any indemnities provided under Tiers 2 and 3 by this **EOC** on account of **Hospital**, nursing, medical or surgical services shall be paid to the **Provider** rendering such services; but it is not required, except as specified in the requirements for coverage under Tiers 2 and 3, that the service be rendered by a particular **Hospital** or person. Any payment made by the **Plan** in good faith pursuant to this provision will fully discharge the **Plan's** obligation to the extent of the payment. The **Member** may request that payments not be made pursuant to this provision. The request must be made in writing and must be given to the **Plan** not later than the time of filing proof of loss. Payment made prior to receipt of the **Member's** written request at the **Plan's** principal executive office will be deemed to be payment made in good faith.

For services provided under Tier 3, the **Member** shall be responsible for the payment of all charges for any service or supply in excess of the **Reasonable Charge** or charges otherwise not covered by this **EOC**.

S. **Time Limitations on Service.** To be eligible for consideration as a **Covered Benefit**, any service or supply sought or received by a **Member** must be billed to and received by the **Plan** no later than twelve (12) months after the date the service was provided unless it is shown to have not been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

DEFINITIONS

The following words and phrases when used in this **EOC** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Active Course of Treatment.** A planned program of services rendered by a **Physician** or DME **Provider**, starting on the date a **Physician** first renders a service to correct or treat the diagnosed condition, covering a defined number of services or period of treatment.
- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.
- **Appropriately Qualified.** A **Health Professional,** acting within the scope of their license, who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the **Member**.
- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Contract Holder.** An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to the **Plan**. The **Contract Holder** shall act only as an agent of the **Plan Members** in the **Contract Holder's** group, and shall not be the agent of the **Plan** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.
- **Coinsurance.** The portion of **Covered Expenses** which a **Member** must pay for care, after first meeting a **Deductible** amount. A **Member** does not have to pay **Coinsurance** after the **Member** reaches the individual and family maximum out-of-pocket limits, if any, as listed on the Schedule of Benefits.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this **EOC** for a description of the **Coordination of Benefits** provision.
- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits.
- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery.** Any non-**Medically Necessary** surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, correct disfigurement caused by an accident or birth defect, or correct or naturally improve a physiological function or provide more than a minimal improvement in the appearance of the **Member**. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

- **Coverage Decision.** The approval or denial of health care services by the **Plan** substantially based on a finding that the provision of a particular service is included or excluded as a **Covered Benefit** under the terms and conditions of this **EOC**. A **Coverage Decision** is not a **Plan** decision regarding a **Disputed Health Care Service.**

- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **EOC**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **EOC**.

- **Covered Dependent.** Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **EOC** has enrolled in the **Plan**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.

- **Covered Expenses.** The **Reasonable Charge** for **Covered Benefits** recognized under this **EOC** as eligible for inclusion in calculating reimbursement.

- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Credible Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided by a separate policy.

- **Custodial Care.** Any type of care including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-**Hospital Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of the **Plan**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.

- **Deductible.** The first payments up to a specified dollar amount which a **Member** must make in the applicable calendar year for **Covered Benefits**.

- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.

- **Disputed Health Care Service.** Any health care service eligible for coverage and payment that has been denied, modified, or delayed by a decision of the **Plan,** or one of its contracting **Providers**, in whole or in part due to a finding that the service is not **Medically Necessar**y.

- **Durable Medical Equipment.** Equipment, as determined by the **Plan**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **EOC** as shown on the records of the **Plan**.

- **Emergency Service(s).** Medical screening, examination and evaluation by a **Physician**, or, to the extent permitted by applicable law, by other **Health Professionals**, to determine if an emergency medical condition, psychiatric emergency medical condition, and/or active labor exists. If such conditions are determined to exist, **Emergency Services** are the care and treatment to relieve or eliminate the emergency medical or psychiatric condition, within the capability of the facility.

- **Evidence of Coverage (EOC).** This **Evidence of Coverage**, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by the **Plan**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  2. required FDA approval has not been granted for marketing; or
  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
  5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
  7. it is provided or performed in special settings for research purposes.

- **Grievance.** A complaint that may or may not require specific corrective action, and is made either in writing or by calling the toll free Member Services number on the ID card to the **Plan.** Any written or oral request that the **Plan** take a specified action or change an identified prior decision made pursuant to **Plan** procedures for submission of **Grievances**. The request must relate to **Covered Benefits**, **Medical Necessity,** quality of care, access to care, or quality of service to be considered a **Grievance.**

- **Group Agreement.** The **Group Agreement** between the **Plan** and the **Contract Holder**, including the Group Application, Cover Sheet, this **EOC**, the Schedule of Benefits, any riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professionals.** A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **Homebound Member.** A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services.** Those items and services provided by **Providers** as an alternative to hospitalization, and approved and coordinated in advance by the **Plan**.

- **Hospice Care.** A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, **Hospice Care Facility**, or a duly licensed **Hospice Care Agency**, and is approved by the **Plan**, and is focused on a

palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than six (6) months to live.

- **Hospice Care Agency**. An agency or organization which:

  1. has **Hospice Care** available twenty-four (24) hours a day;
  2. meets all licensing or certification standards set forth by the jurisdiction where it is located;
  3. provides skilled nursing services; medical social services; psychological and dietary counseling; and bereavement counseling for the immediate family;
  4. provides or arranges for other services which will include services of a **Physician**; physical or occupational therapy; part-time home health aide services which mainly consist of caring for **terminally ill** persons; and inpatient care in a facility when needed for pain control and acute and chronic symptom management;
  5. has personnel which include at least one **Physician**; one R.N. one licensed or certified social worker employed by the Agency; and one pastoral or other counselor;
  6. establishes policies governing the provision of **Hospice Care**;
  7. assesses the patient's medical and social needs;
  8. develops a **Hospice Care** program to meet those needs;
  9. provides an ongoing quality assurance program. This includes reviews by **Physicians**, other than those who own or direct the Agency;
  10. permits all area medical personnel to utilize its services for their patients;
  11. keeps a medical record on each patient;
  13. utilizes volunteers trained in providing services for non-medical needs; and
  14. has a full-time administrator.

- **Hospice Care Facility**. A facility, or distinct part of one, which**:**

  1. mainly provides inpatient **Hospice Care** to terminally ill individuals;
  2. charges its patients;
  3. meets all licensing or certification standards set forth by the jurisdiction where it is located;
  4. keeps a medical record on each patient;
  5. provides an ongoing quality assurance program; this includes reviews by **Physicians** other than those who own or direct the facility;
  6. is run by a staff of **Physicians**; at least one such **Physician** must be on call at all times;
  7. provides, twenty-four (24) hours a day, nursing services under the direction of a R.N.; and
  8. has a full-time administrator.

- **Hospital.** An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the **Plan** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

- **Infertile or Infertility.** The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Inquiry.** A **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided.

- **Life-Threatening Or Seriously Debilitating Condition.** A disease or condition:

  1. where the likelihood of death is high unless the course of the disease is interrupted;

  2. with potentially fatal outcome, where the end point of clinical intervention is survival; or

  3. that causes major irreversible morbidity.

- **Medical Community**. A majority of **Physicians** who are Board Certified in the appropriate specialty.

- **Medical and Scientific Evidence** means any as listed below:

  1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

  2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR).

  3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

  4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Association of Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.

  5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency of Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services.

  6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

- **Medical Emergency.** The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

- **Medical Services.** The professional services of **Health Professionals,** including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of this **EOC**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by the **Plan** of whether health care services are **Covered Benefits** under this **EOC**.

- **Member.** A **Subscriber** or **Covered Dependent** as defined in this **EOC**. Where context permits, "you" or "your" is used in place of "**Member"** or "**Member's".** If the **Member** is a minor, incompetent, or incapacitated, the parent, guardian, conservator, relative or other designee may act on the **Member's** behalf. Therefore, "you" or "your" as used in this **EOC** means "you or the individual acting on your behalf".

- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons or mental illness treatment program, except for transitional living facilities.
- **Non-Participating Provider.** A **Provider** not designated as a **Plan Participating Provider** or such other **Provider** not part of the **Plan** network.
- **Non-Referred Benefits. Covered Benefits** under this **EOC** received from **Participating or Non-Participating Providers** without a prior **Referral** issued by the **Member's Primary Care Physician**.
- **Open Enrollment Period.** A period of not less than thirty (30) consecutive working days, each calendar year, when eligible employees of the **Contract Holder** may enroll in the **Plan** without a waiting period or exclusion or limitation based on health status or, if already enrolled in the **Plan**, may transfer to an alternative health plan offered by the **Contract Holder**.
- **Participating.** A description of a **Provider** that has entered into a contractual agreement with the **Plan** for the provision of services to **Members**.
- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.
- **Plan,** the **Plan.** Aetna U.S. Healthcare of California Inc. a California corporation operating pursuant to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan of 1975.
- **Pre-Authorization/Pre-Certification.** A certification from the **Plan** that a **Member** must obtain prior to receiving any of the services that are identified in this **EOC** as needing **Pre-Authorization/Pre-Certification** in order to receive unreduced benefits.
- **Premium.** The amount the **Contract Holder** or **Member** is required to pay to the **Plan** to continue coverage.
- **Primary Care Physician.** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist, obstetrician, gynecologist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider.** A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.
- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **Plan** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. the **Plan** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of **Providers** in the area.
- **Reconstructive Surgery.** Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: a) improve function and b) create a normal appearance, to the extent possible.
- **Referral.** Specific directions or instructions from a **Member's PCP,** in conformance with the **Plan's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care under this **EOC**.
- **Referred Benefits. Covered Benefits** under this **EOC** received from **Participating Providers** upon prior **Referral** issued by the **Member's Primary Care Physician**.
- **Respite Care.** Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

- **Self-Refer, Self-Referral, Self-Referred.** The act or process whereby a **Member** receives **Covered Benefits** under this **EOC** from **Providers** without obtaining a prior **Referral** from the **Member's Primary Care Physician.**

- **Serious Emotional Disturbances of a Child.** A mental disorder as identified in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. A "child" is a minor under the age of eighteen (18). **Serious Emotional Disturbances of a Child** include but are not limited to: (a) psychotic features, (b) risk of suicide, and (c) risk of violence due to a mental disorder.

- **Serious Mental Illness.** Includes the following conditions that meet the diagnostic criteria described in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders,: (a) schizophrenia, (b) schizoaffective disorder, (c) bipolar disorder, (d) major depressive disorders, (e) panic disorder, (f) obsessive-compulsive disorder, (g) pervasive developmental disorder or autism, (h) anorexia nervosa, or (i) bulimia nervosa.

- **Service Area.** The geographic area, established by the **Plan** and approved by the appropriate regulatory authority.

- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.

- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the **Plan** to meet the reasonable standards applied by any of the aforesaid authorities.

- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

- **Specialty Care Center.** Center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the **Life-Threatening** disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

- **Standing Referral**. A **Referral** by a **PCP** to a **Specialist** for more than one visit to the **Specialist**, as indicated in the treatment plan, if any, without the **PCP** having to provide a specific **Referral** for each visit.

- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **EOC** and on the Schedule of Benefits, has enrolled in the **Plan**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.

- **Substance Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

- **Substance Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

- **Totally Disabled or Total Disability.** A **Member** shall be considered **Totally Disabled** if:

  1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or

  2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

- **Urgent Care. Medically Necessary Covered Benefits** required in order to prevent serious deterioration of a **Member's** health that results from an unforeseen illness or injury if the **Member** is temporarily outside

of the **Plan's Service Area** and receipt of the health care service cannot be delayed until the **Member's** return to the **Service Area.**

AETNA U.S. HEALTHCARE OF CALIFORNIA INC.

(CALIFORNIA)

PRESCRIPTION PLAN RIDER

Aetna U.S. Healthcare of California Inc. ("the **Plan**") and **Contract Holder** agree to offer to **Members** the Prescription Rider, subject to the following provisions:

DEFINITIONS

The Definitions section of the **EOC** is amended to include the following definitions:

- **Brand Name Prescription Drug(s) -** Prescription drug(s) and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by the **Plan** or an affiliate. **Brand Name Prescription Drugs** do not include those drugs classified as **Generic Prescription Drugs** as defined below.
- **Contracted Rate** - The negotiated rate between the **Plan** or an affiliate and the **Participating Retail** or **Mail Order Pharmacy**.
- **Drug Formulary** - A listing of prescription drugs and insulin established by the **Plan** or an affiliate which includes both **Brand Name Prescription Drugs,** and **Generic Prescription Drugs**. The Pharmacy and Therapeutics Committee reviews the Formulary at least annually. Throughout the year the Pharmacy and Therapeutics Committee may evaluate new drugs once they are approved by the FDA, and may re-evaluate the drugs on the current formulary in light of new FDA, manufacturer and peer reviewed information. Further information about the Drug Formulary and the Pharmacy and Therapeutics Committee is located in the Formulary Guide section. An updated copy of the **Drug Formulary** shall be available at any time upon request by the **Member**.
- **Drug Formulary Exclusions List** - a list of prescription drugs excluded from the **Drug Formulary**, subject to change from time to time at the sole discretion of the **Plan**.
- **Generic Prescription Drug(s)** – A prescription drug and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as chemically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.
- **Non-Formulary Prescription Drug(s) -** A product or drug not listed on the **Drug Formulary** which includes drugs listed on the **Drug Formulary Exclusions List.**
- **Participating Mail Order Pharmacy** - A Pharmacy which has contracted with the **Plan** or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to **Members** by mail or other carrier.
- **Participating Retail Pharmacy** - A community pharmacy which has contracted with the **Plan** or an affiliate to provide covered outpatient prescription drugs to **Members**.
- **Precertification Program.** For certain outpatient prescription drugs, prescribing **Physicians** must contact the **Plan** or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by the **Plan** or an affiliate. An updated copy of the list of drugs requiring Precertification shall be available upon request by the **Member**.
- **Therapeutic Interchange Program.** The **Therapeutic Interchange Program** is an educational program through which **Members** and **Physicians** are informed of available drug alternatives where said prescription drug products are considered therapeutically equivalent and clinically efficacious. All substitutions are subject to the prescribing **Physician's** review and approval.

PRESCRIPTION DRUG COVERED BENEFITS

The Covered Benefits section of the **EOC** is amended to add the following provision:

A. **Outpatient Prescription Drugs Open Formulary Benefit**

Medically Necessary outpatient prescription drugs and insulin are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines subject to the terms, the **Plan's** policies, limitations and exclusions described in the **EOC** and this rider. Coverage is based on the **Plan's** or an affiliate's determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with prior authorization from the **Plan**. Items covered by this rider are subject to drug utilization review by the **Plan** and/or **Member's Participating Provider** and/or your **Participating Pharmacy**. Not all **Brand Name Prescription Drugs** are covered.

B. Each prescription is limited to a maximum thirty (30) day supply when filled at a **Participating Retail Pharmacy** or ninety (90) day supply when filled by the **Participating Mail Order Pharmacy** designated by the **Plan.** Prescription refill requests must be made when there are 10 days or less remaining on a prescription filled at a **Participating Retail Pharmacy**, or 22 days or less remaining on a prescription filled through a **Participating Mail Order Pharmacy**. An additional thirty (30) day supply may be obtained by calling UC Care Customer Service and requesting a "vacation over-ride". You will be asked to provide an explanation of the need for the extended supply. For extensive travel out of the country, you can submit an explanation of the need for an extended supply and receive up to a one (1) year supply of prescription drugs through the mail order pharmacy, subject to the applicable copay(s). Please request the vacation override form from UC Care customer service. You should allow at least two weeks to receive your prescription. Prescriptions can only be shipped to an address within the U.S. Except in an emergency or urgent care situation, or when the **Member** is traveling outside the **Plan Service Area**, prescriptions must be filled at a **Participating Retail or Mail Order Pharmacy**. Coverage of prescription drugs may, in the **Plan's** sole discretion, be subject to **Precertification, Therapeutic Interchange Programs** or other **Plan** requirements or limitations.

C. FDA approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. Coverage of off label use of these drugs may, in the **Plan's** sole discretion, be subject to **Precertification Program** or other **Plan** requirements or limitations.

D. **Emergency Prescriptions -** Emergency prescriptions are covered subject to the following terms:

When you need a prescription filled and you do not have access to a **Participating Retail Pharmacy** in an **Emergency** or **Urgent Care** situation, or when you are traveling outside of the **Plan Service Area**, the **Plan** will reimburse you as described below.

When you obtain an **Emergency** or **Urgent Care** prescription at a non-**Participating Retail Pharmacy**, you must directly pay the pharmacy in full for the cost of the prescription. You are responsible for submitting a request for reimbursement in writing to the **Plan** with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by the **Plan** to determine if the event meets the **Plan's** requirements. Upon approval of the claim, the **Plan** will reimburse you directly 100% of the cost of the prescription, less the applicable **Copayment** specified below and any brand name cost differentials as applicable. Coverage for items obtained from non-**Participating Pharmacies** is limited to items obtained in connection with covered **Emergency** and **Out-of-Area Urgent Care** services.

When you obtain an **Emergency** or **Urgent Care** prescription at any **Participating Retail Pharmacy,** including out-of-area **Participating Retail Pharmacies**, you will pay to the **Participating Retail Pharmacy** the **Copayment(s),** plus the brand name cost differentials where applicable and as described below. The **Plan** will not cover claims submitted as a direct reimbursement request from a **Member** for a prescription purchased at a **Participating Retail Pharmacy** except upon professional review and approval by the **Plan** in it's sole discretion.

E. **Mail Order Prescription Drugs.** Subject to the terms and limitations set forth in this rider, **Medically Necessary** outpatient Prescription drugs are covered when dispensed by the **Participating Mail Order Pharmacy** designated by the **Plan** and when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs. **Members** are required to obtain prescriptions greater than a thirty (30) day supply from the designated **Participating Mail Order Pharmacy**. Outpatient prescription drugs will not be dispensed by a **Participating Mail Order Pharmacy** in quantities that are less than a thirty-one **(**31) day supply or more than a ninety (90) day supply (if the **Provider** prescribes such amounts).

F. **Additional Benefits.**

The following prescription drugs, medicines, and supplies are also covered subject to the terms described in this rider:

- **Diabetic Supplies.**

  The following diabetic supplies are covered if **Medically Necessary** upon prescription or upon **a Physician's** order at a zero copayment if filled at a **Participating Retail** or **Mail Order Pharmacy.**

  1. Diabetic needles/syringes.
  2. Test strips for glucose monitoring and/or visual reading.
  3. Diabetic test agents.
  4. Lancets/lancing devices.
  5. Alcohol swabs.

- **Contraceptive Devices.**

  The following contraceptive devices are covered upon prescription or upon the **Physician's** order only at a zero copayment at a **Participating Retail** or **Mail Order Pharmacy**:

  1. Diaphragms, one per calendar year.
  2. Depo provera. The prescription plan **Copayment** applies for each vial up to a maximum of five (5) vials per calendar year.

G. **Copayments.**

You are responsible for the **Copayments** specified in this rider. The **Copayment,** if any, is payable directly to the **Participating Retail or Mail Order Pharmacy** for each prescription (including Oral Contraceptives) at the time the prescription is dispensed. If you obtain more than a thirty (30) day supply of prescription drugs or medicines at the **Participating Mail Order Pharmacy**, not to exceed a ninety (90) day supply, one **Copayment** is payable for each supply dispensed**.** The **Copayment** is not subject to the annual maximum out-of-pocket limit set forth in the Schedule of Benefits for the medical plan, if any.

- If the **Physician** prescribes a covered **Brand Name Prescription Drug** where a **Generic Prescription Drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the $20.00 **Copayment** for the **Brand Name Prescription Drug**. If you request a covered **Brand Name Prescription Drug** where a **Generic Prescription Drug** equivalent is available you will pay the difference in cost between the **Brand Name Prescription Drug** and the **Generic Prescription Drug** equivalent, plus the **Generic Prescription Drug Copayment**.

- **For Prescriptions Filled at Participating Retail Pharmacies:**

  You are responsible for a **Copayment** in the amount of **$10.00** per prescription or refill for a **Generic Prescription Drug**. You are responsible for a **Copayment** in the amount of **$20.00** per prescription or refill when there is no **Generic Prescription Drug** equivalent available for a **Brand Name Prescription Drug**.

- **For Prescriptions filled at Participating Mail Order Pharmacies:**

  If the **Physician** prescribes a covered **Brand Name Prescription Drug** where a **Generic Prescription Drug** equivalent is available and specifies "Dispense As Written" (DAW) or you

request that the prescription be filled with a covered **Brand Name Prescription Drug**, you will pay the **Copayment** for the **Brand Name Prescription Drug**.

You are responsible for a **Copayment** in the amount of **$25.00** per prescription or refill for a **Generic Prescription Drug**.

You are responsible for a **Copayment** in the amount of **$35.00** per prescription or refill for a **Brand Name Prescription Drug.**

H. The Formulary Guide contains drugs that have been reviewed by Aetna U.S. Healthcare's Pharmacy and Therapeutics (P&T) Committee. The P&T Committee reviews the entire Formulary Guide at least annually. The P&T Committee reviews information from a variety of sources, including peer review journals and other independently developed materials. Using this information, the P&T Committee periodically evaluates the therapeutic effectiveness of prescription medications and places them into one of three categories:

Category I -- The drug represents an important therapeutic advance.

Category II The drug is therapeutically similar to other available products.

Category III The drug has significant disadvantages in safety or efficacy when compared to other similar products.

The drugs in Category I are always included on the Aetna U.S. Healthcare Formulary, and the drugs placed in Category III are always excluded from the Aetna U.S. Healthcare Formulary. For therapeutically similar drugs in Category II, Aetna U.S. Healthcare selects drugs for the Formulary based on the recommendations of the P&T Committee, the cost effectiveness of the medication, and other factors.

A copy of the Aetna U.S. Healthcare Formulary, or information about the availability of a specific drug may be requested by calling 1-888-792-8742 or may be accessed through our Internet website at www.aetnaushc.com. (Click on "members" and then "prescription plans" to reach the Formulary information.) Be aware that the presence of a drug on Aetna U. S. Healthcare's Formulary does not guarantee that a member will receive a prescription for that drug from their prescribing provider for a particular medical condition.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

The Limitations and Exclusions section of the **EOC** is amended to include the following limitations and exclusions:

A. **Exclusions**.

Unless specifically covered under this rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over- the-counter (OTC) drug or for which an equivalent over the counter product in strength and dosage form, is available even when a prescription is written, unless otherwise covered by the **Plan**.

2. Any drug determined not to be **Medically Necessary** for the treatment of disease or injury unless otherwise covered under this rider.

3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by the **Plan**.

4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.

5. Needles and syringes, except for diabetic needles and syringes.

6. Any medication which is consumed or administered at the place where it is dispensed, or while a patient is in a hospital, or similar facility; or take home prescriptions dispensed from a **Hospital** pharmacy upon discharge, unless the pharmacy is a **Participating Retail Pharmacy**.

7. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.

8. Drugs used for the purpose of weight reduction (i.e., appetite suppressants), including the treatment of obesity, except when **Pre-Authorized** by the **Plan**.

9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, the **Plan** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.

10. Any refill dispensed more than one (1) year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this rider.

12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.

13. Test agents and devices except for diabetic test agents.

14. Injectable drugs used for the purpose of treating infertility, unless otherwise covered by the **Plan**.

15. Injectables except for insulin and Imitrex.

16. Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this rider**.**

17. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this rider.

18. Replacement for lost, stolen or misplaced prescriptions.

19. Performance, athletic performance or lifestyle enhancement drugs and supplies.

20. Drugs and supplies when not indicated or prescribed for a medical condition as determined by the **Plan** or otherwise specifically covered under this rider or the medical plan.

21. Drugs dispensed by other than a **Participating Retail or Mail Order Pharmacy**, except as **Medically Necessary** for treatment of an emergency or **Urgent Care** condition.

22. Medication packaged in unit dose form. (Except those products approved for payment by the **Plan).**

23. Prophylactic drugs for travel.

24. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna U.S. Healthcare Pharmacy Management Department and Therapeutics Committee.

25. Drugs for the convenience of **Member**s or for preventive purposes unless covered by the **Plan** in its sole discretion.

26. Nutritional supplements.

27. Smoking cessation aids or drugs limited to a ninety (90) day supply.

28. Growth Hormones, except when **Pre-Authorized** by the **Plan**.

B. **Limitations**:

1. A **Participating Retail** or **Mail Order Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

2. Non-**Emergency** and non-**Urgent Care** prescriptions will be covered only when filled at a **Participating Retail Pharmacy** or the designated **Mail Order Pharmacy**. Refer to the **EOC** for a description of **Emergency** and **Urgent Care** coverage. The **Plan** will not reimburse **Members** for out-of-pocket expenses for prescriptions purchased from a **Participating Retail Pharmacy** or a non- **Participating Retail Pharmacy** in non-**Emergency**, non-**Urgent Care** situations. The **Plan** retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Grievance procedure section of the **EOC**.

3. **Members** are required to present their ID card at the time the prescription is filled. A **Member** who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement

from the **Plan** except in an **Emergency** or **Urgent Care** situation and **Member** will be responsible for the entire cost of the prescription.

4. The Continuation and Conversion section of the **EOC** is hereby amended to include the following provision: The conversion privilege does not apply to the **Plan** Prescription Plan.

5. The **Plan** is not responsible for the cost of any prescription drug for which the actual charge to the **Member** is less than the required **Copayment** or for any drug for which no charge is made to the recipient.

AETNA U.S. HEALTHCARE OF CALIFORNIA INC.

BENEFITS UNDER THE USACCESS PROGRAM

SCHEDULE OF BENEFITS

The USAccess plan provides coverage for **Referred** and **Non-Referred Benefits** received from **Participating Providers** and **Non-Participating Providers**.

Covered Benefits, Medical Necessity, precertification, concurrent review, retrospective record review and all other terms and conditions of your health plan are determined at the sole discretion of Aetna U.S. Healthcare (or its designee). This means that some services recommended by your health professional may not be deemed covered benefits as determined by Aetna U.S. Healthcare.

Benefit	Tier 1 Referred Care	Tier 2 Participating Provider Self-Referral*	Tier 3 Non-Participating Provider Self Referred*
Deductible Amount: **The family Deductible is a cumulative Deductible for all family Members.**	**None**	**None**	**$500 per Member per calendar year. $1,500 per family per calendar year.**
Maximum Out-of-Pocket Limit **Includes the Deductible Amount** **Out-of-Pocket expenses paid under Tier 2 and Tier 3 combine to meet the Out-of Pocket maximums.**	**$1,000 per Member or $3,000 per family per calendar year.**	**$3,000 per Member or $9,000 per family per calendar year.**	**$12,000 per Member or $36,000 per family per calendar year.**
In addition to the charges listed on pg. 10 of the EOC, the following expenses do not apply to the out-of-pocket Limit: **Copayments for prescription drugs, in-area chiropractic and acupuncture services, behavioral health program services and amounts used to satisfy the hospital emergency room deductible under the UC Care Tiers 2 and 3 and Out-of-Area benefits.**			
Maximum Benefit for all Services and Supplies: **Combined Tier 2 and Tier 3 lifetime maximum benefit.**	**None**	**$2,000,000 per Member per lifetime.**	**$2,000,000 per Member per lifetime.**
Hospice **inpatient and outpatient**	**None**	**None**	**$10,000 per lifetime.**
Pre-Authorization Penalty Certain services require Pre-certification or benefits will be reduced.	**None**	**None**	**50% per service or supply for all related services and supplies.**

***Certain services require Pre-Authorization or benefits will be reduced. Please refer to the EOC for services requiring Pre-Authorization.**

OUTPATIENT BENEFITS

Benefit	Tier 1 Referred Care Member Responsibility	Tier 2 Participating Provider Self-Referral* Member Responsibility	Tier 3 Non-Participating Provider Self Referred* Member Responsibility
Primary Care Physician Office Visit			
During Office Hours	**$10 copay** **(No copay for children under age 6.)**	**$40 copay**	**40% after Deductible**
Well Baby and Child Care To age 19	**$10 copay** **(No copay for children under age 6.)**	**$40 copay** **(No copay for children under age 2.)**	**40% after Deductible** **(0% for children under age 2.)**
Adult Physical Exam	**$10 copay**	**Not covered**	**Not covered**
Immunizations	**$10 copay** **(No copay for children under age 6.)**	**$40 copay to age 19** **(No copay for children under age 2.)**	**40% after Deductible to age 19** **(0% for children under age 2.)**
Specialist Physician Office Visit	**$10 copay** **(No copay for children under age 6.)**	**$40 copay**	**40% after Deductible**
Outpatient Rehabilitation Benefits: Physical, Speech and Occupational Therapy	**$10 copay**	**$40 copay** **Pre-certification required**	**40% after Deductible** **Pre-certification required**
First Maternity Visit	**$10 copay**	**$40 copay**	**40% after Deductible**
Subsequent Maternity Visits	**$0 copay**	**$0 copay**	**40% after Deductible**
Routine Gynecological Exam(s) 1 visit per 365 days	**$10 copay**	**$40 copay**	**40% after Deductible**
Hospital Outpatient Department Visit (Chemotherapy, Radiation)	**$0 copay**	**$40 copay**	**40% after Deductible**

***Certain services require Pre-Authorization or benefits will be reduced. Please refer to the EOC for services requiring Pre-Authorization.**

Diagnostic Testing at physician's office at facility	 **$0 copay** **$0 copay**	 **$0 copay** **$40 copay**	 **40% after Deductible** **40% after Deductible**
Outpatient Emergency Services **Hospital Emergency Room or Outpatient Department. Waived if admitted. Inpatient copay applies instead.**	**$50 copay**	**$50 copay**	**$50 copay**
Ambulance	**$0 copay**	**$0 copay**	**0%**
Urgent Care Facility	**$50 copay**	**$50 copay**	**$50 copay**
Outpatient Mental Health **Serious Mental Illness is covered the same as any other illness or injury.**	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Outpatient Substance Abuse Visits:	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Outpatient Surgery	**$0 copay**	**$250 copay**	**40% after Deductible**
Outpatient Home Health Visits: **Limited to 1 visit per day; 1 visit equals a period of up to 4 hours or less and equals a visit by a home health agency.** **Tier 2 and 3 combined maximum of 100 visits per calendar year.**	**$0 copay**	**$0 copay**	**40% after Deductible**
Outpatient Hospice Visits	**$0 copay**	**$0 copay**	**40% after Deductible** **$10,000 lifetime maximum combined inpatient and outpatient.**

***Certain services require Pre-Authorization or benefits will be reduced. Please refer to the EOC for services requiring Pre-Authorization.**

Private Duty Nursing	**$0 copay**	**$0 copay**	**40% after Deductible**
Durable Medical Equipment Benefits: **Copayment/Coinsurance** **For Tiers 2 and 3 Precertification is required for equipment leased or purchased over $1,500.**	**$0 copay**	**$0 copay**	**40% after Deductible**
Subluxation/Chiropractic Care Benefits	**$10 copay**	**Not covered**	**Not covered**
Acupuncture Benefits	**$10 copay** **Benefits provided by American Specialty Health Plans**	**Not covered**	**Not covered**
Vision Care **Schedule in EOC applies**	**$10 copay**	**Not covered**	**Not covered**
Hearing exam (audiologist)	**$10 copay**	**$40 copay**	**40% after Deductible**
Hearing Aids **Limited to 2 hearing aids every 36 months.** **$2,000 maximum for Tiers 1, 2 ,3 combined.**	**50%**	**50%**	**50% after Deductible**
Preventive Dental Benefit for children under age 12	**$10 copay**	**Not covered**	**Not covered**

***Certain services require Pre-Authorization or benefits will be reduced. Please refer to the EOC for services requiring Pre-Authorization.**

INPATIENT BENEFITS

Benefit	Tier 1 Referred Care	Tier 2 Participating Provider Self-Referral	Tier 3 Non-Participating Provider Self Referred
Acute Care	**$0 copay**	**$500 copay**	**40% after Deductible**
Mental Health **Serious Mental Illness is covered the same as any other illness or injury.**	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Substance Abuse	**Benefits provided by United Behavioral Health**	**Not covered**	**Not covered**
Maternity	**$0 copay**	**$500 copay**	**40% after Deductible**
Skilled Nursing Facility **For Tier 2 and 3 Combined Maximum of 240 days per calendar year**	**$0 copay**	**$500 copay**	**40% after Deductible**
Hospice	**$0 copay**	**$500 copay**	**40% after Deductible $10,000 lifetime maximum combined inpatient and outpatient.**

***Certain services require Pre-Authorization or benefits will be reduced. Please refer to the EOC for services requiring Pre-Authorization.**

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit	**Member Responsibility**
Participating Retail Pharmacy (maximum 30 day supply)	
Generic Prescription Drugs	**$10**
Brand Name Prescription Drugs When there is no **Generic Prescription Drug** equivalent available or when **Physician** specifically indicates Brand Name Prescription Drug. When you request a Brand Name Prescription Drug instead of its generic equivalent.	**$20** **$10 plus the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug.**
Participating Mail Order Pharmacy (31 – 90 day supply)	
Generic Prescription Drugs	**$25**
Brand Name Prescription Drugs	**$35**
Copayment Exception: Participating Retail and Mail Order	
Contraceptive Devices; Diabetic supplies	**$0**

INDEX

United Behavioral Health

Mental Health
and
Substance Abuse Benefits

EFFECTIVE JANUARY 1, 2001

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Certification

INSURANCE BOOKLET

for Employees of

University of California

(called the Employer)

insured by

UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

CERTIFICATE OF INSURANCE

United HealthCare Insurance Company has issued Group Policy No. GA-11280. It covers certain Employees of the Employer.

The policy provides Behavioral Health Benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of the state where the Employee or Annuitant lives.

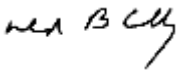
These state benefits and provisions are described in separate Amendments. See the Employer for details.

This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents benefits apply only if the Employee or Annuitant is insured under the Employer's Plan for dependent benefits.

This Certificate describes the Plan in effect as of January 1, 2001.

This Certificate replaces any and all Certificates previously issued for Employees and Annuitants under the plan.

Any coverage provided under this certificate is not in place of Workers' Compensation insurance. It does not affect any requirement for coverage by Workers' Compensation insurance.



UNITED HEALTHCARE INSURANCE COMPANY

The Behavioral Health Benefits described in this Plan are administered by United Behavioral Health.

1-888-440-UCAL (8225)

C-CE2, C-SB1, C-MH3CA, C-CI1, C-CB3, C-RP1, C-GL1

Schedule of Benefits

Effective Date of this Plan January 1, 2001

Behavioral Health Benefits

Mental Health Copayments	
Office Visit Copayment	**Visits 1-5: $0** **Visits 6+: $10***
Deductible and Out-of-Pocket Maximum	
Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible	**$100**
Mental Health Out-of-Pocket Maximum	**$1,000 per person**** **$3,000 per family****
Percentage Payable after Copayments/Deductibles Satisfied	
Mental Health Inpatient and Intermediate Care	**100%**
Substance Abuse Inpatient: Detoxification	**80%**
Substance Abuse Inpatient and Intermediate Care: Rehabilitation	**80% with Treatment Plan Compliance** **50% without Treatment Plan Compliance**
Mental Health Outpatient	**100% after Copayment**
Substance Abuse Outpatient	**80%**
Maximum Benefits	**None**

*Copayment is waived for children to age six.

**The percentage payable is 100% when the Mental Health Out-of-Pocket Maximum is met each Calendar Year.

All benefits are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.

Behavioral Health Benefits

General Information About This Plan

The following sections located at the beginning of this booklet also apply to Behavioral Health Benefits:

--University of California Eligibility, Enrollment, Termination, and Plan Administration Provisions

Additionally, the following sections also apply to Behavioral Health Benefits:

--Termination of Coverage
--Under "Continuation and Conversion," all sections except "Conversion Privilege."

Note: Tiers 1, 2 and 3 do not apply to United Behavioral Health mental health/substance abuse benefits since the United Behavioral Health provider network is available throughout the United States.

What This Plan Pays

Behavioral Health Benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from a Network Provider.

To receive benefits, the Covered Person must call United Behavioral Health (UBH) before Covered Expenses are incurred. (See **Notification Requirements and Utilization Review.**)

Each Covered Person must satisfy certain Copayments and/or Deductibles before any payment is made for certain Behavioral Health Services. The Behavioral Health Benefit will then pay the percentage of Covered Expenses shown in **Schedule of Benefits**.

A Covered Expense is incurred on the date that the Behavioral Health Service is given.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given. The Company, at its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with the methodologies:

- In the most recent edition of the Current Procedural Terminology and/or DSM IV Code;
- As reported by generally recognized professionals or publications.

Behavioral Health Services are services and supplies which are:

- Clinically Necessary, as defined below, for Mental Disorder Treatment.
- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
    - Physician.
    - Psychologist.
    - Registered Nurse.
    - Licensed Counselor.
    - Health Care Provider.
    - Hospital.
    - Treatment Center.

Behavioral Health Services include but are not limited to the following:

- Assessment.
- Diagnosis.
- Treatment Planning.
- Medication Management.
- Individual, family and group psychotherapy.
- Psychological testing.

Telemedicine

Benefits for telemedicine services are payable same as Behavioral Health Benefits. No face-to-face contact is required between a provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.

"Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. It is the above-covered medical services that an individual receives from a provider without person-to-person contact with the provider. It is not consultation by telephone or facsimile machine between providers or between patient and provider.

Services and supplies will not automatically be considered Clinically Necessary because they were prescribed by a provider.

"Clinically Necessary/Clinical Necessity" services or supplies are defined as services and supplies that meet all the following criteria:

- They are consistent with the symptoms and signs of diagnosis and treatment of the Covered Person's behavioral disorder, psychological injury or substance abuse.
- They are consistent in type and amount with regard to the standards of good clinical practice.
- They are not solely for the convenience or preference of the Covered Person, or his/her provider.
- They are the least restrictive and least intrusive appropriate supplies or level of service which can be safely provided to the Covered Person.

The Company may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations regarding whether particular services, supplies or accommodations provided or to be provided to a Covered Person were/are Clinically Necessary.

Notification Requirements and Utilization Review

Except for Emergency Care, to receive benefits under this Plan the Covered Person must call United Behavioral Health (UBH) before Behavioral Health Services are given. **The toll-free number is 1-888-440-UCAL (8225). UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the Utilization Review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

UBH performs a Utilization Review to determine the Clinical Necessity of Behavioral Health Services. The Covered Person and his/her provider decide which Behavioral Health Services are given, but this Plan only pays for Behavioral Health Services that are Clinically Necessary and given by a Network Provider.

Appeals

The Covered Person may appeal a Utilization Review or benefit reduction. Call UBH for further information.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider.

When Emergency Care is required for Mental Disorder Treatment, the Covered Person (or his/her representative or his/her provider) must call UBH within twenty-four (24) hours after the Emergency Care is given. If it is not reasonably possible to make this call within twenty-four (24) hours, the call must be made as soon as reasonably possible. The Company will pay for Emergency Care services regardless of the provider's contract status with the Company.

When the Emergency Care has ended, the Covered Person must get a referral from UBH before any additional services will be covered.

Copayments and Deductibles

Before Behavioral Health Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given.

A Deductible is the amount of Covered Expenses the Covered Person must pay each Calendar Year before Behavioral Health Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentages shown in **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment or Deductible.

Mental Health Office Visit Copayment

The Mental Health Office Visit Copayment applies to all services and supplies given in connection with each office visit.

Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible

The Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible applies to all charges for services or supplies given in connection with Substance Abuse Inpatient and Intermediate Care services each Calendar Year.

Out-of-Pocket Feature

Covered Expenses for office visits for Mental Health are subject to the applicable copayments shown in the Schedule of Benefits until the Mental Health Out-of-Pocket Maximum shown in the Schedule of Benefits has been reached during a Calendar Year. Then, such Covered Expenses are payable at 100% for the rest of that year as shown below.

Individual Mental Health Out-of-Pocket Maximum

When the Individual Mental Health Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, all Covered Expenses for Mental Health are payable at 100% for that same person for the rest of that year.

Family Mental Health Out-of-Pocket Maximum

When the per Family Mental Health Out-of-Pocket Maximum is reached for an Employee and the Employee's family combined in a Calendar Year, all Covered Expenses for Mental Health are payable at 100% for the rest of that year.

Not Covered

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies given by a Non-Network Provider, except when care is received outside the United States.
- Services or supplies which are not Clinically Necessary, including any confinement or treatment given in connection with a service or supply which is not Clinically Necessary.
- Services or supplies received before the Covered Person becomes covered under this Plan.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee or Annuitant for the same services under this Plan.
- Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.
- Completion of claim forms or missed appointments.
- Custodial Care that has not been approved by UBH. This is care made up of services and supplies that meets one of the following conditions:
    - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
    - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

    Care that meets one of the conditions above is custodial care regardless of any of the following:

        - Who recommends, provides or directs the care.
        - Where the care is provided.
        - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's/Annuitant's immediate family:

    - The Employee's/Annuitant’s spouse.
    - The child, brother, sister, parent or grandparent of either the Employee/Annuitant or the Employee's/Annuitant’s spouse.
- Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
- Services and supplies for which the Covered Person is not legally required to pay.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling.
- Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers’ compensation act or similar law. For persons for whom coverage under a workers’ compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers’ compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
- Private duty nursing services while confined in a facility.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Stand-by services required by a Physician.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.
- Services given by volunteers or persons who do not normally charge for their services.

Network Provider Charges Not Covered

A Network Provider has contracted to participate in the Network and provide services at a negotiated rate. Under this contract a Network Provider may not charge for certain expenses, except as stated below. A Network Provider cannot charge for:

- Services or supplies which are not Clinically Necessary;
- Fees in excess of the negotiated rate.

A Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Clinically Necessary. In this case, the Network Provider may make charges to the Covered Person. The Covered Person will be asked to sign a patient financial responsibility form agreeing to pay for the services that are found to not be Clinically Necessary. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Claims Information

How to File a Claim

A claim form does not need to be filed by the Covered Person when a Network Provider is used. The Network Provider will file the claim form on behalf of the Covered Person. All payments will be paid directly to the Network Provider.

The following steps should be completed when submitting bills for payment for services and supplies received outside the United States.

Claims are paid according to billed charges at the appropriate network benefit level based on the rate of exchange on the date that services are rendered. To process the claim, a complete billing statement is required. This billing statement can be combined with a receipt for services. The statement must include the following:

- The Employee/Annuitant's name, Social Security Number, address and phone number.
- The patients's name.
- The Plan number (11280).
- The name, address and phone number of the provider.
- The licensure of the provider.
- The date of service.
- The place of service.
- The specific services provided.
- The amount charged for the service.
- The diagnosis.

The claim/billing statement should be mailed to:

United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250

All payments for services received outside the United States will be paid to the Employee/Annuitant.

When Claims Must be Filed

The covered Employee/Annuitant must give the Company written proof of loss within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

The Company will reimburse claims or any portion of any claim for Covered Expenses, as soon as possible, not later than 30 working days after receipt of the claim. However, a claim or portion of a claim may be contested by the Company. In that case the Employee/Annuitant will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested will identify the portion of the claim that is contested and the specific reasons for contesting the claim. If an uncontested claim is not reimbursed by delivery to the claimants' address of record within 30 working days after receipt, interest will accrue at the rate of 10% per year beginning with the first calendar day after the 30-working-day period.

United Behavioral Health will send an Explanation of Benefits (EOB) to the covered Employee/Annuitant. The EOB will explain how United Behavioral Health considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee/Annuitant will receive a written explanation.

Legal Actions

The covered Employee/Annuitant may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee/Annuitant may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee/Annuitant lives allows for a longer period of time.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for two years. It can be declared invalid due to nonpayment of premium.

No statement used by any person to get coverage can be used to declare coverage invalid if the person has been covered under this Plan for two years. In order to use a statement to deny coverage before the end of two years, it must have been signed by the person. A copy of the signed statement must be given to the person.

Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to Appeals Unit, United Behavioral Health - Employer Division at P.O. Box 32040, Oakland, California, 94604, within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and United Behavioral Health will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, United Behavioral Health's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

Coordination of Benefits

Coordination of benefits applies when a Covered Person has health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. One of the Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Please refer to the section called "Coordination of Benefits" in the In Area EOC and the section called "Effect of Medicare" in the Out-of-Area EOC, for the effect of Medicare on this Plan.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this **Coordination of Benefits** provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
    - Medicare is secondary to the plan covering the person as a dependent.
    - Medicare is primary to the plan covering the person as other than a dependent (example, an Annuitant).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the plan of the parent with custody for the child.
    - Second, the plan of the spouse of the parent with the custody of the child.
    - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor an Annuitant are determined before those of a plan which covers that person as a laid off employee or an Annuitant. The same rule applies if a person is a dependent of a person covered as an Annuitant or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person for the longer period are determined before those of the plan which covered that person for the shorter period.

Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company must get the consent of the Covered Person to do this.

A Covered Person must give the Company the information it asks for about other plans. If any other organization or person needs information to apply its coordination provision, the Company must get the consent of the Covered Person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Company will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

The Company may pay benefits that are in excess of what it should have paid. The Company has the right to recover the excess payment.

Recovery Provisions

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made by the Company exceeded the benefits under this Plan.

The refund equals the amount the Company paid in excess of the amount it should have paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid

If the Company pays benefits for expenses incurred on account of a Covered Person, the Covered Person or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than this Plan as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Subrogation

In the event a Covered Person suffers an injury or sickness as a result of a negligent or wrongful act or omission of a third party, the Company has the right to pursue subrogation where permitted by law.

The Company will be subrogated and succeed to the Covered Person's right of recovery against a third party. The Company may use this right to the extent of the benefits under this Plan.

The Covered Person agrees to help the Company use this right when requested.

Glossary

(These definitions apply when the following terms are used.)

Annuitant

A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan or a deceased Employee’s or Annuitant’s family member receiving monthly benefits from a University-sponsored defined benefit plan ("Survivor Annuitant").

Average Regular Paid Time

For any month, the Employee's average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by the Employee in the preceding twelve (12) month period.

(a) A month with zero regular paid hours which occurred during the Employee's furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when the Employee was not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

(a) If the Employee worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If the Employee did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

Calendar Year

A period of one year beginning with January 1.

Covered Person

The Employee or the Annuitant; his or her legal spouse, Domestic Partner or Adult Dependent Relative; and/or Dependent children who are covered under this Plan, except a Survivor Annuitant may not enroll his/her legal spouse.

Course of Treatment

A period of Mental Disorder Treatment during which Behavioral Health Services are received by a Covered Person on a continuous basis until there is a period of interruption (that is, the Covered Person is treatment-free) for more than:

- 30 days with respect to treatment for substance abuse
- 6 months with respect to treatment for mental illness

Emergency Care

Immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Employee

A person who is appointed to work at least 50% time for twelve months or more or is appointed at 100% time for three months or more. To remain eligible, an Employee must maintain an Average Regular Paid Time of at least 20 hours per week and maintain an eligible appointment of at least 50% time. If the appointment is at least 50% time, the Employee's appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

Health Care Provider

A licensed or certified provider other than a Physician whose services the Company must cover due to a state law requiring payment of services given within the scope of that provider's license or certification.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
    - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
    - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
    - It is operated continuously with organized facilities for operative surgery on the premises.

A psychiatric health facility shall also be deemed a Hospital if it fulfills one of the following requirements:

- It is licensed by the California State Department of Health Services.
- It operates under a waiver of licensure granted by the California State Department of Mental Health.

Intermediate Care

A treatment alternative to an acute inpatient Hospital stay. Intermediate Care includes partial hospitalization, residential care, day treatment and structured outpatient services.

Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or Marriage, Family and Child Counselor (MFCC) by the appropriate authority.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment

Mental Disorder Treatment is Clinically Necessary treatment for both of the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A provider which participates in United Behavioral Health's network.

Non-Network Provider

A provider which does not participate in the network.

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Osteopathy (D.O.).

Plan

The group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Registered Nurse

A graduate trained nurse who is licensed by the appropriate authority and is certified by the American Nurses Association.

Substance Abuse Rehabilitation

Treatment for a substance abuse disorder in a twenty-four hour setting, or other setting outside of an acute care Hospital that is licensed to perform that service and where there is no danger of medical complications due to detoxification.

Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board (if this Plan provides inpatient benefits at a Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Treatment Plan Compliance

The completion of an authorized Inpatient or Intermediate Care Substance Abuse Rehabilitation treatment program.

Utilization Review

A review and determination by United Behavioral Health as to the Clinical Necessity of services and supplies.

End of Certificate

IMPORTANT NOTICE

CLAIM DISPUTES: SHOULD A DISPUTE CONCERNING A CLAIM ARISE, CONTACT THE COMPANY FIRST. IF THE DISPUTE IS NOT RESOLVED, CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE.

CALL THE COMPANY AT THE PHONE NUMBER SHOWN ON YOUR EXPLANATION OF BENEFITS.

CALL THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

1-800-927-HELP (1-800-927-4357) IF THE COVERED PERSON RESIDES IN THE STATE OF CALIFORNIA.

(213) 897-8921 IF THE COVERED PERSON RESIDES OUTSIDE OF THE STATE OF CALIFORNIA.

A COVERED PERSON MAY WRITE THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

CALIFORNIA DEPARTMENT OF INSURANCE
CLAIMS SERVICES BUREAU, 11TH FLOOR
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

American Specialty Health Plans® of California, Inc.

Acupuncture Benefit

EFFECTIVE JANUARY 1, 2001

American Specialty Health Plans® of California, Inc.

P.O. Box 509002

San Diego, CA 92150-9002

(800) 678-9133 (619) 578-2000

ACUPUNCTURE BENEFIT
COMBINED
EVIDENCE OF COVERAGE
AND
DISCLOSURE FORM

NOTE: THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM (THIS "COMBINED EOC") DISCLOSES THE TERMS AND CONDITIONS OF COVERAGE.

THIS COMBINED EOC SHOULD BE READ COMPLETELY AND CAREFULLY, AND INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS SHOULD READ CAREFULLY THOSE SECTIONS THAT APPLY TO THEM. A MEMBER OR APPLICANT FOR MEMBERSHIP MAY USE THE TELEPHONE NUMBER THAT APPEARS AT THE TOP OF THIS COVER PAGE TO RECEIVE ADDITIONAL INFORMATION ABOUT THE BENEFITS OF THE HEALTH PLAN DESCRIBED IN THIS COMBINED EOC.

THIS COMBINED EOC CONSTITUTES ONLY A SUMMARY OF THE HEALTH PLAN CONTRACT OFFERED BY AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA ("ASHP"). THE HEALTH PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE CONTRACT IS AVAILABLE FROM YOUR EMPLOYER GROUP OR ASHP UPON REQUEST.

TABLE OF CONTENTS

General Information About the Plan

I. DEFINITIONS

ASHP means American Specialty Health Plans of California, Inc.

Acupuncture Services are services rendered by an acupuncturist for the treatment of Neuro-musculoskeletal Disorders, Nausea and Pain.

Administrative Review Program is the program and procedures utilized by ASHP to review administrative decisions, such as denial of authorization forms or claims due to late or untimely submission to ASHP by Participating Acupuncturists.

Agreement means the agreement ASHP signed with an Employer Group under which Members are entitled to receive Covered Services.

Combined EOC means this Acupuncture Benefit Combined Evidence of Coverage and Disclosure Form, including the Schedule of Benefits and Premium Table attached to and incorporated by reference into this Combined EOC.

Copayments are payments to be collected directly by a Participating Acupuncturist from a Member for Covered Services.

Covered Services are Acupuncture Services as described in the Schedule of Benefits that are Medically Necessary Services and are pre-authorized by ASHP. All Covered Services, except for (a) an initial examination by a Participating Acupuncturist and the provision or commencement, in the initial examination, of Medically Necessary Services that are Acupuncture Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services, require authorization by ASHP. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Acupuncturist, without additional authorization by ASHP.

Dependent is a Subscriber's enrolled, eligible spouse and/or each enrolled, eligible dependent.

Emergency Services consist of "Emergency Acupuncture Services." Emergency Acupuncture Services are Covered Services that are rendered for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal system, nausea, or pain which manifests itself by acute symptoms of sufficient severity for which a delay of immediate acupuncture attention could decrease the likelihood of maximum recovery.

Employer Group is an employer group, union, association or other entity which contracts with ASHP for the provision of Covered Services to Members.

Experimental or Investigational is acupuncture care that is investigatory or an unproven acupuncture procedure or treatment regimen that does not meet the professionally recognized standards of practice.

Grievance Procedures are ASHP's procedures for reviewing Member complaints.

Health Plan is the health plan contract offered by ASHP and described in this brochure.

Health Plan Premiums are the monthly amounts paid by an Employer Group on behalf of Members for the benefits provided under the Health Plan.

Medically Necessary Services are Acupuncture Services which are:

1) Necessary for the treatment of Neuromusculo-skeletal Disorders, Pain, or Nausea.

2) Established as safe and effective and furnished in accordance with professionally recognized standards of practice for acupuncture treatment of Neuromusculo-skeletal Disorders, Pain, or Nausea.

Medicare is the name commonly used to describe health insurance benefits for the aged and disabled provided under Public Law 89-97, as amended.

Member is any Subscriber or Dependent.

Member Services Department is the person or persons designated by ASHP to whom oral and written Member questions, concerns or complaints may be addressed. The Member Services Department may be contacted by telephone at 1-800-678-9133 or by writing to the Member Services Department at:

American Specialty Health Plans of California, Inc.

P.O. Box 509002

San Diego, CA 92150-9002

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating Acupuncturist in accordance with professionally recognized standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

Neuromusculo-skeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition. Pain includes low back pain, post-operative pain, and post-operative dental pain.

Participating Acupuncturist is an acupuncturist duly licensed to practice acupuncture in California and who has entered into an agreement with ASHP to provide Covered Services to Members.

Premium Table means the Premium Table that sets forth the full amount of the premium payable for Covered Services and is attached to and incorporated by reference into this Combined EOC.

Quality Improvement Program are the procedures and standards established and administered by ASHP to ensure that Covered Services rendered by a Participating Acupuncturist comply with professionally recognized standards of practice.

Schedule of Benefits is the schedule of Covered Services available to a Member under the Health Plan that is attached to and incorporated by reference into this Combined EOC.

Service Area is the geographic area in which ASHP is licensed to provide or arrange for Acupuncture Services in the State of California by the California Department of Managed Health Care.

Subscriber is the person whose employment or other status, except for family dependency, is the basis for eligibility for membership under the Health Plan.

Utilization Management Program is an ASHP program to promote the efficient use of resources and maintain the quality of care which includes, but is not limited to, the prospective, concurrent and retrospective review of Covered Services.

II. CHOICE OF PROVIDERS; ACCESS TO PARTICIPATING ACUPUNCTURISTS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY RECEIVE COVERED SERVICES.

A. GENERAL

Except as otherwise indicated in this Combined EOC, a Member must receive Covered Services from a Participating Acupuncturist. A Member will have direct access to Participating Acupuncturists without obtaining a physician referral. A Member may simply call a Participating Acupuncturist to schedule an initial examination. After the initial examination--except for services provided pursuant to a treatment plan approved by ASHP and Emergency Services--the Member's Participating Acupuncturist must obtain pre-authorization for any additional Covered Services for a Member. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Acupuncturist, without additional authorization by ASHP. Except as

otherwise indicated in this Combined EOC, the Participating Acupuncturist will be responsible for filing all claims with ASHP.

A Member may receive Acupuncture Services from any Participating Acupuncturist. Except for Emergency Services, and in certain circumstances in counties in which there are no Participating Acupuncturists, ASHP will not pay non-Participating Acupuncturists for any services. A non-Participating Acupuncturist is an acupuncturist who has not entered into an agreement with ASHP to provide Covered Services to Members. Please note the following:

- A Member may receive Emergency Services from any acupuncturist, including a non-Participating Acupuncturist if the delay caused by seeking immediate acupuncture attention from a Participating Acupuncturist could decrease the likelihood of maximum recovery. ASHP will pay the non-Participating Acupuncturist for the Emergency Services to the extent they are Covered Services.
- If a Member lives in a county in which there are no licensed acupuncturists or no Participating Acupuncturists, ASHP will refer the Member to a Participating Acupuncturist in a neighboring county. If the Member requests access to a non-Participating Acupuncturist located nearer to the Member's home, ASHP will refer the Member to a non-Participating Acupuncturist who is located nearer to the Member's home and will pay the non-Participating Acupuncturist for any services rendered to the Member to the extent they are Covered Services.

B. FILING AND PAYMENT OF MEMBER CLAIMS (REIMBURSEMENT PROVISIONS); MEMBER LIABILITY

ASHP will pay claims for Emergency Services that are Covered Services and for other Covered Services that are not available and accessible to a Member and either are provided upon a referral by ASHP or, with regard to radiology and clinical laboratory services for acupuncture enrollees, are provided upon referral by a Participating Acupuncturist.

A Member may be liable to a provider for such Covered Services if the provider is not a Participating Acupuncturist. If a Member must pay for such Covered Services, ASHP will reimburse the Member. When a Member receives a bill from a provider for such Covered Services, the Member must file a claim with ASHP. If the Member has not paid the bill, ASHP will pay the provider. If the Member has paid the bill, ASHP will pay that amount to the Member. The Member must pay the Copayment for any such Covered Services.

Members must file claims for Emergency Services or other Covered Services within ninety (90) days after receiving the Emergency Services or other Covered Services. If it is not reasonably possible for a Member to file a claim for Emergency Services or other Covered Services within ninety (90) days, the Member must file the claim as soon as reasonably possible after the end of the ninety (90) day period. A Member must use ASHP's forms in filing a claim and should send the claim form to ASHP at the address listed in the claim form or to ASHP at:

American Specialty Health Plans of California, Inc.

P.O. Box 509002

San Diego, CA 92150-9002

Attention: Claims Department

ASHP will give claim forms to Members on request. For more information regarding claims, and to obtain an ASHP claim form, Members may call ASHP at 1-800-678-9133 or write ASHP at the address given immediately above. ASHP's Director of Acupuncture Services will decide whether Acupuncture Services are or were Medically Necessary Services and therefore are or were Covered Services. ASHP may use

utilization review procedures that it has developed for this purpose. ASHP will disclose to a member, on request, the process that it uses to approve or deny services under the Health Plan. ASHP must approve the provision of any services other than an initial examination by a Participating Acupuncturist and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, a re-examination in subsequent office visit, or Emergency Services, including without limitation, any referral of a Member for x-ray services, radiological consultations, or laboratory services. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Acupuncturist without additional authorization by ASHP.

C. SECOND OPINIONS

If a Member would like a second opinion with regard to Covered Services provided by a Participating Acupuncturist, the Member will have direct access to any other Participating Acupuncturist. The Member's visit to a Participating Acupuncturist for purposes of obtaining a second opinion generally will count as one visit and the Member must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Participating Acupuncturist. However, a visit to a second Participating Acupuncturist to obtain a second opinion will not count as a visit if the Member was referred to the second Participating Acupuncturist by another Participating Acupuncturist (the first Participating Acupuncturist).

D. PAYMENTS TO PARTICIPATING ACUPUNCTURISTS

ASHP pays each Participating Acupuncturist a negotiated fee for Covered Services provided to ASHP's Members.

ASHP will not pay a bonus to anyone to deny, reduce, limit, or delay the provision of Covered Services that are Medically Necessary Services.

A Member may request additional information about these issues from ASHP. A Member also may request such information from a Participating Acupuncturist. To request information from ASHP, please call 800-678-9133 or please write to Member Services Department, American Specialty Health Plans of California, Inc. P.O. Box 509002, San Diego, CA 92150-9002.

E. MEMBER'S FINANCIAL RESPONSIBILITY

If a Member receives services that are <u>not</u> Covered Services, the provider of those services may bill the Member directly and the Member—not ASHP—must pay the provider. The Member will have no right to request reimbursement from ASHP in such a situation, and ASHP will have no obligation to reimburse a Member for any such services.

There are various instances in which a Member might receive services from a provider that are not Covered Services, including, but not limited to, the following:

- The Member receives Covered Services, other than Emergency Services, from a non-Participating Acupuncturist without authorization from ASHP.

- The Member receives services that are not Covered Services. This might occur, for example, if a Member desires to receive services from a Participating Acupuncturist that are excluded from coverage, such as services for the treatment of asthma or addiction.

In situations such as those described in the two bullet points set forth immediately above, ASHP will have no obligation to pay the provider of those services or to pay or reimburse the Member for those services.

There are other instances in which a Member might receive services that are not Covered Services including, but not limited to, the following:

- The person who received the services was not a Member at the time he or she received the services. This might occur, for example, if an individual receives services before he or she meets the eligibility requirements established by the Employer Group or if an individual receives services after termination of the Member's coverage under the Health Plan. It also might occur, for example, if the individual is not properly enrolled pursuant to the Agreement signed by ASHP and the Employer Group or if the individual is not listed on an eligibility tape provided to ASHP by the Employer Group.

In the situation set forth immediately above, ASHP will have no obligation to pay or reimburse the Member for those services.

ASHP distinguishes between "eligibility" for services and "authorization" of services. "Eligibility" depends on an individual's status as a Member and the availability of Covered Services to the Member. "Authorization" relates to any required approval of Covered Services as Medically Necessary Services.

If ASHP authorizes the provision of services to an individual, including a Member, and subsequently determines that the individual was not eligible for those services, ASHP will have no obligation to pay or reimburse the individual for those services. The individual who received the services will be responsible for paying for them.

A MEMBER IS RESPONSIBLE FOR KNOWING WHETHER HE OR SHE IS ELIGIBLE TO RECEIVE COVERED SERVICES. IF AN INDIVIDUAL RECEIVES SERVICES FOR WHICH HE OR SHE IS NOT ELIGIBLE, INCLUDING SERVICES RECEIVED BY A MEMBER TO THE EXTENT THEY EXCEED ANY APPLICABLE MAXIMUM BENEFIT AND SERVICES RECEIVED BY AN INDIVIDUAL AT A TIME WHEN HE OR SHE WAS NOT A MEMBER, THAT INDIVIDUAL MUST PAY FOR THOSE SERVICES, EVEN IF ASHP AUTHORIZED THEM, AND THE PROVIDER MAY BILL THE INDIVIDUAL FOR THOSE SERVICES DIRECTLY. IF ASHP HAS PAID FOR THE SERVICES IN ANY SUCH SITUATION OR HAS REIMBURSED AN INDIVIDUAL OR A MEMBER FOR THE COST OF THE SERVICES IN ANY SUCH SITUATION, ASHP MAY SEEK REIMBURSEMENT FROM THE INDIVIDUAL OR THE MEMBER FOR THE AMOUNT PAID BY ASHP TO THE PROVIDER, THE INDIVIDUAL, OR THE MEMBER.

III. CONTINUITY OF CARE

A Member receiving Covered Services from a Participating Acupuncturist at the time the Participating Acupuncturist's contract terminates with ASHP may be able to continue to receive Covered Services from that provider for a period of time. The Member must be receiving Covered Services for an acute condition, a serious chronic condition, or a pregnancy at the time the provider's contract with ASHP terminates. A Member's ability to receive continuity of care in these situations will depend on a number of other factors, including whether the provider voluntarily terminated his or her contract with ASHP and whether the provider agrees in writing to be subject to the same contract terms that existed prior to termination. A Member should contact ASHP in writing or by telephone to request continuity of care in such a situation. ASHP can be reached by calling 800-678-9133 or by writing to Member Services Department, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

IV. ELIGIBILITY

A Subscriber and the Subscriber's Dependents may enroll in ASHP if the Subscriber and Dependents meet the eligibility requirements of the Employer Group and reside within the Service Area. Please refer to the University of California "Eligibility, Enrollment, Termination and Plan Administration Provisions" in Part I of the UC Care Plan booklet.

V. ENROLLMENT

Please refer to the University of California "Eligibility, Enrollment, Termination and Plan Administration Provisions" in Part I of the UC Care Plan booklet.

VI. TERMS OF COVERAGE

Prepayment Fees: The Employer Group will pay ASHP the Health Plan Premium on Member's behalf. A Subscriber should contact his or her Employer Group regarding any required employee contribution.

ASHP will cover only Acupuncture Services that are Covered Services. Please note that the services listed in the "General Exclusions and Limitations" section of the Schedule of Benefits are not covered.

ASHP may change any provision of the Health Plan, including the Covered Services, Health Plan Premiums and Copayments, after two hundred ten (210) days written notice of such change has been given to the Employer Group, subject to review and approval by the California Department of Managed Health Care.

VII. OTHER CHARGES

A Member receiving Covered Services will only be responsible for applicable Copayments or deductibles described in the Schedule of Benefits. Such Copayments and deductibles must be paid by the Member to the Participating Acupuncturist when the services are rendered. Copayments and deductibles are listed in the Schedule of Benefits. A Member may also obtain services not covered by ASHP at the Member's own expense.

VIII. COORDINATION OF BENEFITS

If a Member is covered by ASHP and another plan or contract providing acupuncture benefits or services, including Medicare, ASHP's benefits and services shall be coordinated with such other plan or contract in accordance with state and federal laws and regulations. Members must inform ASHP if they are covered by any other acupuncture benefit plan, including Medicare. If ASHP pays benefits in excess of those required under coordination of benefits laws and regulations, ASHP or a Participating Acupuncturist may recover an excess payment from a Member or the other plan. ASHP may also reduce its coverage of a Member to avoid duplication of benefits available under Medicare. A Member who is eligible for Medicare coverage, but elects not to enroll in Medicare, may have his or her benefits reduced as though he or she received Medicare benefits.

IX. RENEWAL PROVISIONS

The health plan contract entered into by ASHP and the Employer Group sets forth the Member's rights and benefits. That contract will automatically renew unless terminated by ASHP or the Employer Group. Members should contact their Employer Group with questions regarding the renewal or termination of that contract. At the time of renewal, ASHP has the right to change the Health Plan Premiums or any other provision of that contract.

X. COVERED SERVICES

For a detailed listing of Covered Services, Members should review the Schedule of Benefits. Please note that the amount of Covered Services will be limited based on the Schedule of Benefits.

Acupuncture Services that are Covered Services include Medically Necessary Services rendered by an acupuncturist for treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation, and tennis elbow.

Acupuncture Services that are Covered Services do not include services for treatment of asthma or addiction (including, without limitation, smoking cessation).

All Covered Services--except for (a) an initial examination by a Participating Acupuncturist and the provision or commencement, in the initial examination, of Medically Necessary Services that are Acupuncture Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services--require pre-authorization by ASHP. When ASHP approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by Acupuncturist, without additional approval by ASHP.

A. EMERGENCY SERVICES

ASHP covers Emergency Services. Because ASHP arranges only Acupuncture Services, if a Member believes the Member requires medical services in an emergency, ASHP recommends that the Member consider contacting his or her primary care physician or another physician or calling “911”. Members are

encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when they have an emergency medical condition that requires an emergency response.

ASHP will not cover any services as Emergency Services unless the acupuncturist rendering such services can show that the services, in fact, were Emergency Services.

B. COPAYMENTS OR DEDUCTIBLES

A Member must pay Copayments or deductibles at the time Covered Services are rendered. The Copayment or deductible will be a specific dollar amount. The Schedule of Benefits attached to and incorporated by reference into this Combined EOC sets forth the applicable Copayments or deductibles under the heading "BENEFIT PLAN".

C. ASHP PAYMENTS

ASHP will pay each Participating Acupuncturist directly. California law provides, by statute, that each contract between ASHP and a Participating Acupuncturist must provide that, if ASHP fails to pay the Participating Acupuncturist, no Member shall be liable to the Participating Acupuncturist for any sums owed by ASHP.

D. MEMBER'S LIABILITY

A Member may be liable to a Participating Acupuncturist for services not covered under the Health Plan. A Member will be liable to a non-Participating Acupuncturist for the cost of services if a Member chooses to receive services from a non-Participating Acupuncturist, other than: (i) Emergency Services; (ii) services pursuant to a referral by ASHP in a situation in which there are no Participating Acupuncturists in the county in which the Member lives who are available and accessible to the Member but there are non-Participating Acupuncturists located in that county who are available and accessible to the Member; and (iii) services pursuant to a referral by ASHP in a situation in there is no Participating Acupuncturists in the county in which the Member lives who are available and accessible to the Member but there are non-Participating Acupuncturists located in a neighboring county who are available and accessible to the Member.

XI. TERMINATION OF BENEFITS

Please refer to the University of California "Eligibility, Enrollment, Termination and Plan Administration Provisions" in Part I of the UC Care Plan booklet.

XII. REINSTATEMENT OF BENEFITS

Please refer to the University of California "Eligibility, Enrollment, Termination and Plan Administration Provisions" in Part I of the UC Care Plan booklet.

XIII. INDIVIDUAL CONTINUATION OF BENEFITS

Please refer to the University of California "Eligibility, Enrollment, Termination and Plan Administration Provisions" in Part I of the UC Care Plan booklet.

XIV. MEMBER RIGHTS

A. QUESTIONS, CONCERNS OR COMPLAINTS?

If a Member has a question, concern, or complaint regarding the services received from ASHP or a Participating Acupuncturist, the Member should call ASHP at 1-800-678-9133 or write ASHP at the following address:

American Specialty Health Plans of California, Inc.

Member Service Department

P.O. Box 509002

San Diego, CA 92150-9002

A Member may also obtain a Member complaint form from any Participating Acupuncturist.

B. GRIEVANCE PROCEDURES AND ARBITRATION

Member Services Department

If a Member calls ASHP, the Member Services Department is ready to assist the Member with filing a complaint. Such assistance includes helping the Member in writing the complaint.

Grievance Procedures

ASHP will work with the Member to resolve the complaint. ASHP will follow its Grievance Procedures in this regard.

ASHP's Grievance Procedures, which ASHP has filed with the Department of Managed Health Care, provide that a complaint or grievance that might involve a quality of care issue or any other clinical issue with regard to acupuncture services (a "clinical complaint") will be reviewed by an ASHP Acupuncture Case Manager who is a licensed acupuncturist. If a complaint or grievance does not involve a quality of care issue or any other clinical issue (an "administrative complaint"), a First Level Review Committee composed of two members of ASHP's Administrative Review Committee will review the complaint or grievance. The Administrative Review Committee includes officers, directors, and employees of ASHP.

Clinical Complaints

ASHP will resolve each clinical complaint within thirty (30) days. If a clinical complaint involves an imminent and serious threat to the health of a Member—including, but not limited to, severe pain, potential loss of life, limb, or major bodily function—ASHP will review the clinical complaint on an expedited basis and will send the Member (and, if appropriate, the Department of Managed Health Care) a written statement that sets forth the disposition or status of the clinical complaint within three (3) days from receipt of the clinical complaint.

If a Member is dissatisfied with the initial determination of a clinical complaint made by an ASHP Acupuncture Case Manager, the Member may request a redetermination by ASHP's Director of Acupuncture Services, who is a licensed acupuncturist. The Member may do so by submitting a written request to ASHP's Director of Acupuncture Services within thirty (30) days from the Member's receipt of a written statement that sets forth the initial determination made by the Acupuncture Case Manager. ASHP's Director of Acupuncture Services shall send the Member a written statement of the redetermination made by ASHP's Director of Acupuncture Services and shall do so within thirty (30) days from the date of receipt of the request for redetermination.

If the Member is dissatisfied with the redetermination made by ASHP's Director of Acupuncture Services, the Member may request a final redetermination by ASHP's Acupuncture Quality Improvement Committee (the "Acupuncture QIC") or ASHP's Acupuncture Utilization Management Committee (the "Acupuncture UMC"). The Member may do so by submitting a written request to the Acupuncture QIC or the Acupuncture UMC within thirty (30) days from the Member's receipt of a written statement that sets forth the redetermination made by ASHP's Director of Acupuncture Services. The Acupuncture QIC or the Acupuncture UMC shall send the Member a written statement of final redetermination made by the Acupuncture QIC or the Acupuncture UMC and shall do so within thirty (30) days from the date of receipt of the request for final redetermination.

The written statement of redetermination from ASHP’s Director of Acupuncture Services will indicate whether a request for final redetermination should go to the Acupuncture QIC or to the Acupuncture UMC. The Acupuncture QIC will make any final redetermination of a clinical complaint to the extent it does not involve a determination as to the status of services as Medically Necessary Services, and the Acupuncture UMC will make any final redetermination of a clinical complaint to the extent it does involve a determination of the status of services as Medically Necessary Services. The Acupuncture QIC and the Acupuncture UMC each is composed solely of licensed acupuncturists.

If the Member is still dissatisfied, the Member may submit the clinical complaint to binding arbitration, as discussed below, and, also discussed below, a Member may submit a clinical complaint to the Department of Managed Health Care, even if the Member has not submitted the dispute to binding arbitration. If the Member does not submit a request for binding arbitration within sixty (60) days from the Member's receipt of the written statement of final redetermination by the Acupuncture QIC or the Acupuncture UMC, the final redetermination made by the Acupuncture QIC or the Acupuncture UMC shall be final and binding.

Administrative Complaints

ASHP will resolve each administrative complaint within thirty (30) days. If an administrative complaint involves an imminent and serious threat to the health of a Member—including, but not limited to, severe pain, potential loss of life, limb, or major bodily function—ASHP will review the administrative complaint on an expedited basis and will send the Member (and, if appropriate, the Department of Managed Health Care) a

written statement that sets forth the disposition or status of the clinical complaint within three (3) days from receipt of the clinical complaint.

If a Member is dissatisfied with the initial determination of an administrative complaint made by the First Level Review Committee, the Member may request a redetermination by the entire Administrative Review Committee. The Member may do so by submitting a written request to the Administrative Review Committee within thirty (30) days from the Member's receipt of a written statement that sets forth the initial determination made by the First Level Review Committee. The Administrative Review Committee shall send the Member a written statement of the redetermination made by Administrative Review Committee and shall do so within thirty (30) days from the date of receipt of the request for redetermination.

If the Member is dissatisfied with the redetermination made by the Administrative Review Committee, the Member may request a final redetermination by ASHP's President. The Member may do so by submitting a written request to ASHP's President within thirty (30) days from the Member's receipt of a written statement that sets forth the redetermination made by the Administrative Review Committee. ASHP's President shall send the Member a written statement of final redetermination made by ASHP's President and shall do so within thirty (30) days from the date of receipt of the request for final redetermination.

If the Member is still dissatisfied, the Member may submit the administrative complaint to binding arbitration, as discussed below, and, also discussed below, a Member may submit an administrative complaint to the Department of Managed Health Care, even if the Member has not submitted the dispute to binding arbitration. If the Member does not submit a request for binding arbitration within sixty (60) days from the Member's receipt of the written statement of final redetermination by ASHP's President, the final redetermination made by ASHP's President shall be final and binding.

Binding Arbitration

As discussed above, if a Member is dissatisfied with the final determination of a clinical complaint or an administrative complaint, the Member may submit the matter to binding arbitration after the Member completes ASHP's Grievance Procedures.

The requirement that a Member submit a dispute to binding arbitration applies broadly, including to settle any claim of malpractice against ASHP. A Member's claims against a Participating Acupuncturist are not subject to ASHP Grievance Procedures, except to the extent the Member and the Participating Acupuncturist agree to follow and/or be bound by ASHP's Grievance Procedures. If a Member has a claim against a Participating Acupuncturist, the Member may seek any available remedy against the Participating Acupuncturist.

The Member and ASHP will follow applicable law with regard to arbitration and ASHP's arbitration policies. California law may require, for a dispute involving $200,000 or less, that the Member and ASHP select a single, neutral arbitrator. In that situation, the arbitrator will not have the power to award more than $200,000.

At a Member's request, ASHP will send the Member a copy of ASHP's arbitration policies. Those policies, as ASHP may amend them from time to time, will bind the Member and ASHP.

If a Member seeks to arbitrate a dispute under or with regard to the Agreement, the Member must give notice to ASHP, and, if ASHP seeks to arbitrate a dispute, ASHP must give notice to the Member. The

notice must contain a demand for arbitration and must describe the dispute, the issues involved, the amount of any claim, and the remedy sought.

Any arbitration under the Health Plan will be held in accordance with the Commercial Arbitration Rules of the American Arbitration Association (the "AAA") and must be submitted to the AAA in accordance with those procedures. Any arbitration under the Agreement will be held in California at a location mutually acceptable to the parties, provided that, if the parties cannot agree on a location for the arbitration, the AAA shall specify the location. In cases of extreme hardship, ASHP will pay all or a part of a Member's fees and expenses for a neutral arbitrator.

Department of Managed Health Care

In some cases, a Member may file a complaint with the Department of Managed Health Care and a Member may submit a complaint to the Department of Managed Health Care, even if the Member has not submitted the dispute to binding arbitration. California law sets forth this right in the following statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number **(1-800-400-0815)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (**1-800-735-2929 (TTY) or 1-888-877-5378 (TTY**)) to contact the department. The department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-800-678-9133** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

A Member may submit a complaint or grievance to the Department of Managed Health Care for review after the Member has participated in ASHP's grievance process for at least thirty (30) days. If the Member's grievance involves an imminent and serious threat to his or her health—including, but not limited to, severe pain, potential loss of life, limb, or major bodily functions—the Member may submit the grievance to the Department of Managed Health Care without waiting thirty (30) days. In such a situation, ASHP also will provide the Member and, as appropriate, the Department of Managed Health Care with a written statement of the status or disposition of the complaint within three (3) days of receipt of the complaint.

C. INDEPENDENT MEDICAL REVIEW OF DELAYS, DENIALS, OR MODIFICATIONS OF EXPERIMENTAL OR INVESTIGATIONAL THERAPIES

Covered Services do not include services, lab tests, x-rays and other treatments classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If ASHP denies coverage for services for a Member based on a determination by ASHP that the services are Experimental or Investigational, the Member may be able to request an independent medical review of ASHP's determination in accordance with the requirements of California Health and Safety Code Section 1370.4.

California Health and Safety Code Section 1370.4 applies only if five specified criteria are met:

1. The Member has a life-threatening or seriously debilitating condition;
2. Standard therapies are ineffective or inappropriate for that condition or are not more beneficial to the Member than the Experimental or Investigational services;
3. The Experimental or Investigational services are more likely to be beneficial to the Member;
4. ASHP has denied coverage for the Experimental or Investigational services;
5. Except for that denial, the Experimental or Investigational services otherwise would be Covered Services.

If ASHP denies coverage for Experimental or Investigational services, ASHP will notify the Member in writing of the opportunity to request an independent medical review within five (5) business days of the decision to deny coverage. ASHP will provide the Member with an application to be submitted to the California Department of Managed Health Care, and the review will be conducted by an independent medical review organization that has contracted with the Department of Managed Health Care to provide such services.

D. CANCELLATION

If a Member believes that his or her Health Plan enrollment was cancelled or not renewed because of the Member's health status or requirements for health care services, such Member may seek a review of the cancellation by the California Department of Managed Health Care.

E. MEMBER PARTICIPATION IN ASHP PUBLIC POLICY

ASHP has established a Public Policy Committee to make recommendations regarding ASHP's public policy. To participate in this committee or to request additional information regarding the development of ASHP's public policies, please call ASHP at 1-800-678-9133.

XV. PATIENTS' RIGHTS AND RESPONSIBILITIES

We acknowledge that you, our patients, entrust us with your special care and needs. Because of this, we have adopted the following list of patients' rights and responsibilities. As a patient you have the right to:

1. Considerate and respectful care.
2. Receive information about your illness in understandable terms so that you may give informed consent (except in emergencies, this information should include the proposed course of treatment, alternatives, possibilities of non-treatment, prospects for recovery, and clinical risks involved).

3. Use the information you have received to participate – to the extent permitted by law – in decisions regarding care, including the right to refuse treatment.

4. Full consideration of privacy, including case discussion, consultation, examination and treatment, all of which are confidential and should be conducted discreetly, with your consent to the presence of any third parties.

5. Reasonable continuity of care and advance notification of the appointment time and location as well as the identity of the person(s) providing care.

6. Be advised of and refuse treatment if your health care provider engages in experimental studies/procedures affecting your care or treatment.

7. Be informed of continuing health care requirements following discharge from treatment.

8. Receive medically necessary and appropriate care and services, as defined in your member benefit plan.

9. File complaints and grievances when dissatisfied with the treatment you have received.

10. Request and receive any available information about health education, promotion, and prevention services; community services that may help to assist with your health problems; and the appropriate use of treatments, regardless of their relationship to your health care benefits.

11. Examine and receive an explanation regarding any charges billed to you.

12. Have these rights apply to the person who has legal responsibility for making decisions regarding your medical care.

13. Exercise these rights without regard to gender; ethnic, cultural, economic, educational, or religious background; or the source of payment for care.

14.

As a patient you must also take responsibility to:

15. Give your health care provider and/or health plan the information necessary to provide you with the best possible care

16. Follow the treatment plan and instructions for care upon which you and your health care provider have agreed.

(A01/01:UC9/19/01)

AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA, INC.

ACUPUNCTURE

SCHEDULE OF BENEFITS

BENEFIT PLAN: Plan number ACU20]

No Deductibles;

$10 Copayment Per Visit

Unlimited Visit Annual Maximum

Benefits include Acupuncture Services that are Medically Necessary Services rendered by an acupuncturist for treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation, and tennis elbow. All Covered Services—except for (a) an initial examination by a Participating Acupuncturist and the provision or commencement, in the initial examination, of Medically Necessary Services that are Acupuncture Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services--require authorization by ASHP. When ASHP approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Acupuncturist, without additional approval by ASHP.

PROVIDER ELIGIBILITY:

ASHP only contracts with duly licensed California acupuncturists, chiropractic radiologists, radiology groups, clinical laboratory groups, medical radiologists, medical pathologists and hospitals. Members must use Participating Providers.

TYPES OF COVERED SERVICES:

a) An initial examination is performed by the Participating Acupuncturist to determine the nature of the Member's problem, to provide or commence, in the initial examination, Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from a Participating Acupuncturist for any injury, illness, disease, functional disorder, or condition with regard to which the member is not, at that time, receiving services from the Participating Acupuncturist. A Copayment will be required for such examination.

b) Subsequent office visits, as set forth in a treatment plan approved by ASHP, may involve acupuncture treatment, a brief re-examination, and other services, in various combinations. A Copayment will be required for each visit to the office.

c) Adjunctive therapy, as set forth in a treatment plan approved by ASHP, may involve therapies such as acupressure, breathing techniques, exercise, nutrition, and oriental massage.

d) A re-examination may be performed by the Participating Acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASHP. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.

X-rays and laboratory tests are payable in full when referred by a Participating Acupuncturist and authorized by ASHP. Radiological consultations are a covered benefit when authorized by ASHP as Medically Necessary Services.

EXCLUSIONS AND LIMITATIONS

Benefits do not include services that are not described under "Type of Covered Services" and "Benefit Plan," above, and do not include, without limitation, services for treatment of asthma or addiction (including, without limitation, smoking cessation). In addition to any other applicable "limitations" contained elsewhere in the evidence of coverage provided to a Member, ASHP shall not be required to furnish benefits in connection with the following:

1. Any services or treatments not authorized by ASHP, except for (a) an initial examination by a Participating Acupuncturist and the provision or commencement, in the initial examination, of Medically Necessary Services that are Acupuncture Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Acupuncturist without additional authorization by ASHP.
2. Any services or treatments not delivered by a Participating Acupuncturist or other ASHP contracted provider for the delivery of acupuncture care to Members, except for Emergency Services or services that are not available and accessible to a Member and are provided upon a referral by ASHP or, with regard to radiology and clinical laboratory services for acupuncture enrollees, upon referral by a Participating Acupuncturist.
3. Services for examinations and/or treatments for conditions other than those related to Neuromusculo-skeletal Disorders, Nausea, or Pain from Participating Acupuncturists, including, without limitation, services for examinations and/or treatments for asthma or addiction, including, without limitation, smoking cessation.
4. Hypnotherapy, behavior training, sleep therapy and weight programs.
5. Thermography.
6. Services, lab tests, x-rays and other treatments not documented as medically necessary as appropriate or classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If ASHP denies coverage for a therapy for a Member who has a life-threatening or seriously debilitating condition based on a determination by ASHP that the therapy is Experimental or Investigational, the Member may be able to request an independent medical review of ASHP's determination. The Member should contact ASHP's Member Services Department at 1-800-678-9133 for more information.
7. Services and/or treatments which are not documented as Medically Necessary Services.

8. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, and any types of diagnostic radiology other than covered plain film studies.
9. Transportation costs including local ambulance charges.
10. Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
11. Services or treatments for pre-employment physicals or vocational rehabilitation.
12. Any services or treatments caused by or arising out of the course of employment or covered under a final judgment, compromise or settlement as a result of injuries caused by a third party.
13. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment.
14. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
15. Services provided by an acupuncturist practicing outside the State of California, except for Emergency Services.
16. Hospitalization, anesthesia or other related services.
17. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
18. Adjunctive therapy not associated with spinal, muscle or joint manipulation.
19. Vitamins, minerals, nutritional supplements or other similar products.
20. Services for examinations and/or treatments for allergies.
21. Services that are not within the scope of licensure for a licensed acupuncturist in California, including, without limitation, ear coning and Tui Na. Ear coning, also sometimes called “ear candling”, involves the insertion of one end of a long, flammable cone (the “ear cone”) into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called “Oriental Bodywork” or “Chinese Bodywork Therapy”, utilizes the traditional Chinese medical theory of *Qi* but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA, INC.
ACUPUNCTURE
SCHEDULE OF BENEFITS

AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA, INC.

ACUPUNCTURE

PREMIUM TABLE

Prepayment Fees: This Premium Table sets forth the full premium charge for the Group Subscriber Agreement described below. If you are a Subscriber, please contact your Employer Group to determine the amount, if any, of any contribution you must make to the full premium charge.

GROUP NAME:	The Regents of the University of California
GROUP CODES:	HP97300AC
EFFECTIVE DATE:	January 1, 2001
PLAN CODE:	ACU20
PLAN DESCRIPTION:	$10 Copayment Unlimited annual office visit maximum
HEALTH PLAN PREMIUMS:	$0.75 per Member per Month

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