UNIVERSITY OF CALIFORNIA

January 1, 2006

Blue Cross PPO Plan
Retirees with Medicare Part A only or Part B only
Medical Benefits – CA Residents

RT175011-3 106 (DA31)

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the health plan contract upon request.

Plan Summary of Changes Effective January 1, 2006

Unless otherwise indicated, effective January 1, 2006, the following is a summary of the most important changes and clarifications that will apply to your Plan coverage for the year 2006.

Transgender Surgery Benefits

Transgender Surgery Benefits were added to your Plan effective July 1, 2005. Effective January 1, 2006, they are discussed in this Evidence of Coverage booklet. For details, please turn to pages 1, 2, 17, 20, 24, 26, 35, and 52 of this booklet.

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University of California - Blue Cross PPO Plan
In California with Medicare

BENEFITS AT A GLANCE

This is a brief review of your benefits. For complete information, including the terms and conditions of this plan and exclusions and limitations, please refer to the entire Evidence of Coverage and Disclosure Form.

Medical Benefits Calendar Year Deductible *(PPO & Non-PPO calendar year deductibles are exclusive of each other)*		
PPO Providers & Other Health Care Providers	$250/member; $750/family	
Non-PPO Providers	$500/member; $1,500/family	
Transgender Surgery Benefits Calendar Year Deductible	$250/member/$750/family	
Penalty for not obtaining preauthorization where required:	$200/occurrence	
Annual out-of-pocket maximums *(PPO & Non-PPO out-of-pocket maximums are exclusive of each other)*		
PPO Providers & Other Health Care Providers	$3,000/member/year; $9,000/family/year	
Non-PPO Providers	$6,000/member/year; $18,000/family/year	
The following do not apply to out-of-pocket maximums: percentage copays for behavioral health services; non-covered expense; non-compliance penalty charges; charges in excess of customary and reasonable. After a member reaches the out-of-pocket maximum, the member remains responsible for behavioral health services; non-compliance penalties; costs in excess of customary and reasonable charges.		
Lifetime Maximum	$5,000,000/member	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospital Medical Services *(preauthorization required for non-emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	40%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Ambulatory Sur4gical Centers *(preauthorization required for non-emergency services)*		
➢ Outpatient surgery, services & supplies	20%	40%
Skilled Nursing Facility *(preauthorization required)*		
➢ Semi-private room, services & supplies *(limited to 240 days/calendar year)*	20%	40%
Hospice Care		
➢ Inpatient or outpatient services for members with up to one year life expectancy	20%	20%
Home Health Care *(preauthorization required)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	40%
Registered Special Duty Nurse *(outpatient only; preauthorization required)*	20%	40%
Home Infusion Therapy *(preauthorization required)*	20%	40%
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services		
Physician Medical Services		
➢ Office & home visits	20%	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
Diagnostic X-ray & Lab *(including mammograms, Pap smears, & prostate cancer screenings)*	20%	40%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Preventive Care		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam		
-birth to age 7	No copay	No copay
-age 7 & older	20% *(deductible waived)*	40%
➢ Vision Exams *(when medically necessary)*	20%	Not covered
➢ Hearing Exams	20%	40%
➢ Hearing Aids *($2,000 maximum; maximum 2 hearing aids every 36 months, analog and digital devices are covered)*	50%	50%
➢ Allergy testing & treatment *(including serums)*	20%	40%
Physical Therapy, Physical Medicine & Occupational Therapy	20%	40%
Chiropractic Services	20%	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	20%	20%
Acupuncture		
➢ Services for the treatment of disease, illness or injury	20%	40%
Temporomandibular Joint Disorders *(preauthorization required)*		
➢ Splint therapy & surgical treatment	20%	40%
Family planning services		
➢ Infertility studies & tests	20%	40%
➢ Tubal ligation	20%	40%
➢ Vasectomy	20%	40%
➢ Counseling & consultation	20%	40%
➢ Elective abortion	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	20% *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone*)	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered)*		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	20%	40%
Transgender Surgery* *(deductible applies)*		
➢ Inpatient hospital services	20%	Not covered
➢ Physician office visits, including specialists	20%	Not covered
➢ Surgeon, assistant surgeon	20%	Not covered
➢ Anesthetist	20%	Not covered
➢ Skilled nursing facility *(preauthorization required)* Limited to 240 days/calendar year	20%	Not covered
➢ Rehabilitative care	20%	Not covered
➢ Transgender Surgery travel expense (*deductible waived*) Transportation limited to 6 trips/episode & $250/person/trip for round trip, coach fare, hotel limited to1 room double occupancy, $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip.	No copay	Not covered
➢ Transgender Surgery Lifetime Maximum: $75,000		

**Benefits provided through authorized Transgender Surgery physicians only.*

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Organ & Tissue Transplants *(preauthorization required; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	Not covered
➢ Physician office visits *(including specialists and consultants)*	20%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	
MedCall®		
➢ A 24-hour service that connects members to a nurse or audio library with a toll-free call; the number is printed on the member's ID card	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	20%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery	20%	20%
Durable Medical Equipment		
➢ Rental or purchase of DME including dialysis equipment & supplies, & medically necessary therapeutic shoes & inserts	20%	20%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%	20%
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%	20%
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%	20%
Emergency Care		
➢ Emergency room services & supplies	20%	20%
➢ Inpatient hospital services & supplies	20%	20% first 48 hours; 40% after 48 hours *(unless member can't be moved safely)*
➢ Ambulatory surgical center services & supplies	20%	20%
➢ Physician services	20%	20%

NOTES:

Members **residing outside of the PPO service area will be reimbursed at the PPO benefit level.** ***Members*** **are responsible for 20% of the Customary & Reasonable allowance plus the difference between the Customary & Reasonable allowance and billed charges.**

Members **traveling out of the country will be reimbursed at the PPO benefit level.** ***Members*** **are responsible for 20% of the billed charges.**

Mental and Nervous Disorders and Substance Abuse Benefits are provided through United Behavioral Health (UBH) Insurance Company.

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January 1, 2006

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"), and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), Point-of-Service (POS) or Preferred Provider Organization (PPO) Plan, 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 Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscribers

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 or have accumulated 1,000* hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. 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)."

*****Lecturers – see your benefits office for eligibility.

****** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability 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 Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and

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

Survivor: A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

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If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree 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, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: 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 disability 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 claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income, 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 at least 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 a same sex domestic partner (and the same sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations. Effective January 1, 2005, the University will recognize an opposite-sex partner as a Family Member that is eligible for coverage in UC-sponsored benefits if the Employee/Retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the Employee/Retiree and domestic partner are at least 18 years of age.

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An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

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, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both 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 or eligible domestic partner's coverage but not under both. Additionally, a Child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the web site: http://atyourservice.ucop.edu.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, 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.

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

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

- the date you or your Spouse has the legal right to control the Child's health care, or
- 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 (or if the employer stops contributing toward the other coverage for you or your Family Members), 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, POS or EPO plan and you move or are transferred out of that plan's service area, or will be away from the plan'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 plan's service area.

At Other Times For Employees And Retirees

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

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

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

If you are a Survivor, you may not enroll your legal Spouse or domestic partner.

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 a Retiree 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.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

- the date the Child becomes eligible, or
- a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree 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 employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2004, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retirees or Family Members become covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.

b) Individuals who are not eligible for premium-free Part A.

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, as well as submit a copy of your Medicare card. This notifies the

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University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center or from the web site: http://atyourservice.ucop.edu/forms_pubs. Completed forms should be returned to University of California, Human Resources and Benefits, Health and Welfare Administration–Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Medicare Secondary Payer (MSP) Law

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their Spouses who are age 65 or older and eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

MEDICARE PRIVATE CONTRACTING PROVISION AND PROVIDERS WHO DO NOT ACCEPT MEDICARE

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. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, 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. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

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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.

Deenrollment 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 a Retiree or Survivor 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 deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment 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 deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 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 University's "At Your Service" website (http://atyourservice.ucop.edu). 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 a Retiree.

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 Benefit Agreement. 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
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

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

Claims under the Plan are processed by Blue Cross of California at the following address and phone number:

Blue Cross of California
21555 Oxnard Street
Woodland Hills, CA 91367

Blue Cross's Customer Service number is (888) 209-7975

Group Case Number. The Group Case Number for this Plan is: 175011

Type of Plan. This Plan is a health and welfare plan that provides group medical 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. *Plan benefits are not accrued or vested benefit entitlements.* The right to terminate or amend applies to all Employees, Retirees 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 premiums *that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.*

Financial Arrangements. The benefits under the Plan are provided by Blue Cross of California under a Group Benefit Agreement. The cost of the premiums is currently shared between you and the University of California.

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

Agent for Serving of Legal Process. Legal process may be served on Blue Cross of California at the 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 and other specified sites, all Plan documents, including the Group Benefit Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

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

Claims under the Plan. To file a claim or to appeal a denied claim, refer to pages 52, 57, 60 and 67 of this document.

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 of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers. We have established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO), which we call the Prudent Buyer Plan. They have agreed to provide our members with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We publish a directory of Participating Providers. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number listed on your ID card and ask us to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at **www.bluecrossca.com/uc**, or you can call the Blue Cross customer service unit at 1 (888) 209-7975.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the *negotiated rates* and other provisions of a Prudent Buyer Plan contract.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of our Prudent Buyer Plan provider network.

Reproductive Health Care Services. 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 treatment; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Member Rights. You have the right to:

- Receive clear and accurate information about Blue Cross of California, your rights and responsibilities, your health plan benefits and services, and how and when you can use them;
- Receive the names and contact information of participating doctors, *hospitals*, pharmacies, and other health care providers available to you;
- Be treated with courtesy, respect, and dignity;
- Your privacy and to have your personal health information be kept secure and confidential;
- Be involved with doctors and other health care professionals in decision-making regarding your health care;
- Talk over your health care needs with the health care professionals caring for you, including a clear and open discussion about appropriate or medically necessary care available for your condition, without concern for the cost or whether it is covered by your health plan benefits;
- Make a written or spoken suggestion, expression of dissatisfaction, or complaint about the care or service you received from a participating health professional or provider, or about the service you received from your health plan, and you may appeal any decision made relating to you or your health plan benefits and/or health plan services; and
- Write to Blue Cross of California with ideas or questions about this statement on *member* rights and responsibilities. Your letter can be sent to Quality Improvement Department, Attn: Rights and Responsibilities, Mailstop AC-6G, P.O. Box 70000, Van Nuys, CA 91470-0001.

Member Responsibilities. To assist participating health care professionals and providers in meeting these responsibilities to you, it is your duty to:

- Give patient identification and medical information, to the best of your ability, that your health care professionals and providers need in order to care for you and for your health plan to provide services to you;
- To the best of your ability, work with your doctor to be aware of and understand your health issues so you can participate in developing mutually agreed-upon treatment goals;
- Follow the prescribed medical treatment plan and health care instructions that you have agreed upon with your doctor or other health care professional and tell him or her if you decide to take part in any Blue Cross of California-sponsored health activity or program;
- Treat all health care professionals with courtesy and respect;
- Keep scheduled appointments for care and give adequate advance notice of delay or cancellation; and
- Read and understand to the best of your ability all materials concerning your health benefits or ask for clarification as needed.

Centers of Expertise Transplant Facilities. We have established a Centers of Expertise (COE) network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). **These procedures are covered only at a COE.** These "COE" agree to accept the *COE negotiated rate* as payment in full for covered services. A *participating provider* in the Prudent Buyer Plan network is not necessarily a *Centers of Expertise* transplant facility.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS A COVERED EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE US AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult your employer's health plan contract with us to determine the exact terms and conditions of your coverage.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this *plan* are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

IMPORTANT NOTICE ABOUT YOUR MEDICAL BENEFITS

Your *plan* has Utilization Review Program and Authorization Program requirements. These are explained in the Medical Management section beginning on page 45. **Your benefits may be reduced** if you do not follow the procedures outlined. If you have any questions about the Utilization Review Program or Authorization Program requirements, call us at the toll-free number on your identification card.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

Participating Providers and
Other Health Care Providers

- Member Deductible ..... **$ 250**
- Family Deductible ..... **$ 750**

Non-Participating Providers

- Member Deductible ..... **$ 500**
- Family Deductible **$1,500**

Non-Certification Deductible ..... **$ 200**

EXCEPTIONS: In certain circumstances, one or more of these deductibles may not apply, as described below:

– The Calendar Year Deductible will not apply to *physician's* services for routine examinations and immunizations provided under Well Baby and Well Child Care when the services are provided by a *participating provider*.

– The Calendar Year Deductible will not apply to Preventive Care services when the services are provided by a *participating provider*.

– The Calendar Year Deductible will not apply to office visits for pregnancy and maternity care when the services are provided by a *participating provider*.

– The Calendar Year Deductible will not apply to transplant travel expenses authorized by us. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.

– The Non-Certification Deductible will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider*. See MEDICAL MANAGEMENT PROGRAMS.

CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

Co-Payments. After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for the following percentages of *covered expense* you incur:

- *Participating Providers* **20%**
- *Other Health Care Providers* **20%**
- *Non-Participating Providers* **40%**

EXCEPTIONS:

– You are not required to make Co-Payment for services of a *physician* for routine physical examinations and immunizations for a *child* under seven years of age. You remain responsible for charges in excess of *covered expense* for services of a *non-participating provider*.

– Your Co-Payment for Hearing Aids will be **50%**, plus charges in excess of *covered expense.*

– Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed *covered expense*.

a. *Emergency services* provided by other than a *hospital;*

b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Co-Payment will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in our judgment, cannot be safely moved);

c. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* (see MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM);

d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist);

e. Cancer Clinical Trials;

f. Outpatient Speech Therapy;

g. Diabetes Education Programs;

h. Prosthetic Devices; or

i. Durable Medical Equipment.

– Your Co-Payment will be **20%** for organ and tissue transplants authorized by us and performed at an approved transplant center. **Services for organ and tissue transplants are not covered when performed by a *non-participating provider*.** See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

For "specified" organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) authorized by us and performed at a designated *COE* will be **20%**. **Services for specified organ transplants are not covered when performed at other than a designated *COE*.** See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

– No Co-Payment will be required for the transplant travel expenses authorized by us. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

Out-of-Pocket Amount. After you have made the following total out-of-pocket payments for *covered expense* you incur during a *calendar year,* you will no longer be required to pay a Co-Payment for the remainder of that *year,* but you remain responsible for costs in excess of *covered expense*.

Per Member*:*

- *Participating providers* **$3,000**
- *Non-participating providers* **$6,000**

Per Family:

- *Participating providers* **$9,000**
- *Non-participating providers* **$18,000**

Exceptions:

- You will be required to continue to pay your Co-Payment for the following services even after you have reached your Out-of-Pocket Amount. In addition, any Co-Payments you make for such services will not be applied toward reaching that amount.

  -- Co-Payments made for services covered through **United Behavioral Health**, your mental health care benefits carrier.

- Medical Management Program penalties, expense which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense,* will not be applied toward your Out-of-Pocket Amount and are always your responsibility.

MEDICAL BENEFIT MAXIMUMS

We will pay for the following services and supplies, up to the maximum amounts or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care ..... **240 days**
  per *calendar year*

Home Health Care

- For covered home health services ..... **100 visits**
  per *calendar year*

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
  - For transportation to the *COE* **$250**
    per trip for each person
    for round trip coach airfare
  - For hotel accommodations **$100**
    per day, for up to 21 days per trip,
    limited to one room, double occupancy
  - For expenses such as meals **$25**
    per day for each person,
    for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the *COE* **$250**
    for round trip coach airfare
  - For hotel accommodations **$100**
    per day, for up to 7 days
  - For expenses such as meals **$25**
    per day, up to 7 days

Hearing Aids

- For covered charges **$2,000**
  per set of hearing aids,
  every thirty-six (36) month period

Lifetime Maximum

- For all medical benefits **$5,000,000**
  during your lifetime

IMPORTANT NOTE

MEMBERS RESIDING OUTSIDE OF THE PPO SERVICE AREA WILL BE REIMBURSED AT THE PPO BENEFIT LEVEL. *MEMBERS* ARE RESPONSIBLE FOR **20%** OF THE CUSTOMARY & REASONABLE ALLOWANCE PLUS THE DIFFERENCE BETWEEN THE CUSTOMARY & REASONABLE ALLOWANCE AND BILLED CHARGES.

MEMBERS TRAVELING OUT OF THE COUNTRY WILL BE REIMBURSED AT THE PPO BENEFIT LEVEL. *MEMBERS* ARE RESPONSIBLE FOR **20%** OF THE BILLED CHARGES.

TRANSGENDER SURGERY BENEFITS

CALENDAR YEAR DEDUCTIBLES*

- Member Deductible ..... **$ 250**
- Family Deductible ..... **$ 750**

EXCEPTION: The Calendar Year Deductible will not apply to Transgender surgery travel expenses authorized by us. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.

***Note:** The PPO Calendar Year Deductibles for Medical Benefits and Transgender Surgery Benefits are combined. Any *covered expense* that applies toward one, applies toward the other. If you satisfy your *member* deductible under Transgender Surgery Benefits, the corresponding PPO deductible for Medical Benefits is also satisfied.

CO-PAYMENTS

The following is a list of the amounts for which you are responsible for each covered medical service or supply. If a co-payment is expressed as a percentage, it is a percentage of *covered expense*. Please see the section entitled YOUR MEDICAL BENEFITS: TRANSGENDER SURGERY BENEFITS for more details.

Hospital Services

- Inpatient services and supplies **20%**
- Operating room and special treatment room **20%**
- Intensive care **20%**
- Nursing care **20%**
- Blood, blood plasma, derivatives and factors **20%**
- Inpatient drugs, medications and oxygen **20%**
- Outpatient services (except emergency room) **20%**

Skilled Nursing Facility Services

- Skilled nursing care **20%**

Physician

- Office visit **20%**
- Visit to *member's* home **20%**
- Inpatient visit **20%**
- Surgeon, including surgical assistant **20%**
- Administration of anesthesia **20%**
- Rehabilitative care **20%**
- Visit to a *specialist* **20%**

Transgender Surgery Travel Expense

- Transgender surgery travel expense ..... **No charge**

MAXIMUMS

We will pay for the following services and supplies, up to the maximum amounts or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care..... **240 days**
  per *calendar year*

Transgender Surgery Travel Expense

- For each surgical procedure (limited to 6 trips)
  - For transportation to the facility where the surgery is to be performed.....**$250**
    for round trip coach airfare
  - For hotel accommodations.....**$100**
    per day, for up to 21 days per trip, limited to one room, double occupancy
  - For expenses such as meals.....**$25**
    per day, for up to 21 days per trip

Transgender Surgery Lifetime Maximum.....**$75,000**
during your lifetime

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

We will pay for *covered expense* you incur under this *plan*. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted by us for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and COE. The maximum *covered expense* for services provided by a *participating provider* or *COE* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* and *COE* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider,* you will not be responsible for any amount in excess of the *negotiated rate*. If you receive an authorized, specified organ transplant at a *COE*, you will not be responsible for any amount in excess of the *COE negotiated rate* for the covered services of a *COE*.

If you go to a *hospital* which is a *participating provider,* you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider,* you should request that all your provider services (such as services by an anesthesiologist) be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center.* An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Non-Participating Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* will always be the lesser of the billed charge or (1) for a *physician,* the *customary and reasonable charge* or (2) for other than a *physician,* the *reasonable charge*. You will be responsible for any billed charge which exceeds the *customary and reasonable charge* or the r*easonable charge*.

The maximum *covered expense* for *non-participating providers* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital,* in excess of the approved amount as determined by Medicare; or
2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* stated above, or the approved amount as determined by Medicare; or
4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the maximum *covered expense* stated above, or the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this *plan*.

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After we subtract any applicable deductible and your Co-Payment, we will pay benefits up to the amount of *covered expense,* not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only charges that are considered *covered expense* will apply toward satisfaction of any deductible, except as specifically indicated in this booklet.

Calendar Year Deductibles. Each *year*, you will be responsible for satisfying the *member's* Calendar Year Deductible before we begin to pay benefits. If *members* of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all *family members* will be considered to have been met.

- **Participating Providers, COE and Other Health Care Providers.** *Covered expense* for the services of all providers will be applied to the *participating provider, COE* and *other health care provider* Calendar Year Deductibles. When these deductibles are met, however, the *plan* will pay benefits only for the services of *participating providers, COE* and *other health care providers*. We will not pay any benefits for *non-participating providers* unless the separate *non-participating provider* Calendar Year is met.

- **Non-Participating Providers.** *Covered expense* for the services of all providers will be applied to the *non-participating provider* Calendar Year Deductibles. The *plan* will pay benefits for the services of *non-participating providers* only when the applicable *non-participating provider* deductible is met.

Non-Certification Deductible. Each time you are admitted to a *hospital* or have outpatient surgery at an *ambulatory surgical center* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to services provided by a *participating provider* or for *emergency* admissions or procedures. Certification is explained in MEDICAL MANAGEMENT PROGRAMS: UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment from the amount of *covered expense* remaining.

If your Co-Payment is a percentage, we will apply the applicable percentage to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-Of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments equal to your Out-Of-Pocket Amount during a *calendar year*, you will no longer be required to make Co-Payments for any *covered expense* you incur during the remainder of that *year*.

Participating Providers, COE and Other Health Care Providers. Only *covered expense* for the services of a *participating provider, COE* or *other health care provider* will be applied to the *participating provider, COE* and *other health care provider* Out-Of-Pocket Amount. After this Out-Of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *participating provider, COE* or *other health care provider* for the remainder of that *year*.

Non-Participating Providers. Only *covered expense* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-Of-Pocket Amount. After this Out-Of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *non-participating provider* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-Of-Pocket Amount. The following expenses will not be applied toward satisfaction of an Out-Of-Pocket Amount and are always your responsibility:

- Medical Management Program penalties that may apply;
- Expense which is incurred for non-covered services or supplies;
- Expense which is in excess of the amount of *covered expense;*
- Co-Payments made for services covered through **United Behavioral Health**, your mental health care benefits carrier.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by Blue Cross, or any of its affiliates, which is sponsored by the *group*.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between us and the *hospital,* or unless your *physician* orders, and we authorize, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 240 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. If you do not obtain the required authorization, your benefits may be reduced. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.

Home Health Care. The following services provided by a *home health agency:*

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by the *home health agency*.

In no event will benefits exceed 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to prior authorization to determine medical necessity. If you do not obtain the required authorization, your benefits may be reduced. Please refer to MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to us every 30 days.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. If you do not obtain the required authorization, your benefits may be reduced. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Outpatient Private Duty Nursing. We will pay for private duty nursing services of a licensed nurse (R.N., L.P.N. or L.V.N.) for a non-hospitalized acute illness or injury, provided your *physician* orders, and we authorize, the services as *medically necessary*.

If you do not obtain the required authorization, your benefits may be reduced. See MEDICAL MANAGEMENT PROGRAMS for details. Private duty nursing services for custodial care is not covered.

"Private duty" means a session of four or more hours that continuous nursing care is furnished to you alone.

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.

2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.

4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.

2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.

3. We will pay for other *medically necessary prosthetic devices,* including:

    a. Surgical implants;

    b. Artificial limbs or eyes; and

    c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Custom fitted orthotics that restrict or prevent the motion of a weak or diseased part of the body and medicall necessary therapeutic shoes and inserts. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is enrolled under the *plan*.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The organ or tissue recipient; or
2. The organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not an enrolled *member* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

If you do not obtain the required authorization, your benefits may be reduced. Also, *covered expense* does not include charges for services which are provided at a facility other than a transplant center approved by us. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

You must obtain our prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to preoperative tests and postoperative care. Specified organ transplants must be performed at a *Center of Expertise (COE)*. **Charges for services provided for or in connection with a specified**

organ transplant performed at a facility other than a *COE* will not be considered *covered expense*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Transplant Travel Expense. The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a *COE*, provided the expenses are authorized by us (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.):

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
    a. Round trip coach airfare to the *COE*, not to exceed **$250** per person per trip.
    b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
    c. Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
    a. Round trip coach airfare to the *COE*, not to exceed **$250**.
    b. Hotel accommodations, not to exceed **$100** per day for up to 7 days.
    c. Other expenses, such as meals, not to exceed **$25** per day, for up to 7 days.

Well Baby and Well Child Care (Dependent Children Under 19 Years of Age). The following services for a dependent *child* under 19 years of age:

1. *Physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations.
4. Screening for blood lead levels as prescribed by a *physician*.

Preventive Care (Members Age 19 and Over). We will pay for the following services when provided for *members* age 19 and over:

1. A *physician's* services for routine physical examinations.
2. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination.
3. Immunizations.

Hearing Exams. Hearing examinations.

Vision Examinations. Vision exams when *medically necessary* and only when provided by a *participating provider*.

Allergy. Allergy testing and treatment, including serum.

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

1. The treatment provided in a clinical trial must either:
    a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
    b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the cost of non-covered services:

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.

5. Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

For payment for *non-participating providers*, the cost will be based on the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider.*

Coverage for clinical trials is restricted to *participating providers* in the state of California unless the protocol for the clinical trial is not provided for at a California *hospital* or by a California *physician*.

Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Chiropractic Care. Chiropractic services for manual manipulation of the spine to correct subluxation demonstrated by *physician*-read x-ray.

Family Planning. Family planning services, counseling and planning for problems of fertility and *infertility*, as *medically necessary*. Diagnosis and testing for *infertility*.

Infertility treatment, including GIFT, ZIFT, artificial insemination, in vitro fertilization, and any related laboratory procedures are not covered.

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.

Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians.*
2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

These items and services are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment"). Covered charges for hearing aids are limited to **$2,000** per set of hearing aids, every thirty-six (36) months.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:
    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
    b. Insulin pumps.
    c. Pen delivery systems for insulin administration (non-disposable).
    d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.
    e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").
2. Diabetes education program which:
    a. Is designed to teach a *beneficiary* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
    b. Includes self-management training, education, and medical nutrition therapy to enable the *beneficiary* to properly use the equipment, supplies, and medications necessary to manage the disease; and
    c. Is supervised by a *physician*.

    Diabetes education services are covered under *plan* benefits for office visits to *physicians*.
3. The following items are covered as medical supplies:
    a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
    b. Testing strips, lancets, and alcohol swabs.

Jaw Joint Disorders. We will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

If you do not obtain the required authorization, your benefits may be reduced. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Christian Science Benefits. The following provisions relate only to charges for Christian Science treatment:

1. A Christian Science sanatorium will be considered a *hospital* under the *plan* if it is accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

2. The term *physician* includes a Christian Science practitioner approved and accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Benefits for the following services will be provided when a *member* manifests symptoms of a covered illness or injury and receives Christian Science treatment for such symptoms.

1. Services provided by a Christian Science sanatorium if the *member* is admitted for active care of an illness or injury.

2. Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions of **MEDICAL CARE THAT IS NOT COVERED** apply equally to Christian Science benefits as to all other benefits and providers of care.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the “Cancer Clinical Trials” provision under the section MEDICAL CARE THAT IS COVERED.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in “Injectable Drugs and Implants for Birth Control” provision in MEDICAL CARE THAT IS COVERED.

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

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility,* except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Education or Counseling. Educational services, or nutritional counseling, except as specifically provided or arranged by us, or as stated under the "Diabetes" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Food or dietary supplements, except as specifically stated under the “Special Food Products” provision of MEDICAL CARE THAT IS COVERED.

Excess Amounts. Any amounts in excess of *covered expense* or the Medical Benefit Maximums.

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. This exclusion will not apply to services and supplies for routine patient care costs in connection with phase I, phase II, phase III and phase IV cancer clinical trials, as specifically stated under the "Cancer Clinical Trials" provision of MEDICAL CARE THAT IS COVERED. In addition, if you have a life-threatening or seriously debilitating condition and we determine that requested treatment is not a covered service because it is *experimental* or *investigative*, you may request an independent medical review as described in GRIEVANCE PROCEDURES.

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

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

Hearing Aids or Tests. Hearing aids, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as specifically provided under "Hearing Exams and "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis of infertility, except as specifically stated in "Family Planning" provision of MEDICAL CARE THAT IS COVERED. Treatment of *infertility,* including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

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

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

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions.

Note: Services for treatment of *mental or nervous disorders* and substance abuse are not covered by Blue Cross under this *plan*. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by the *group*.

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

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined.

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

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Vision Exams" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Orthodontia. Braces and other orthodontic appliances or services.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except as specifically stated in the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Health Care" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

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

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

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

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse, except as specifically stated in "Outpatient Private Duty Nursing" provision of MEDICAL CARE THAT IS COVERED.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Preventive Care", "Cervical Cancer Screening", "Breast Cancer" or "Prostate Cancer Screening" provisions of MEDICAL CARE THAT IS COVERED.

Scalp hair prostheses. Scalp hair prostheses including wigs or any form of hair replacement.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Sex Transformation. Any procedures to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

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

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

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and

5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

TRANSGENDER SURGERY BENEFITS

This *plan* provides benefits for many of the charges incurred by you or your *family member* for transgender surgery (also known as sex reassignment surgery). Not all charges are eligible and some are only eligible to a limited extent. Transgender surgery must be performed at a facility designated and approved by us for the type of transgender surgery requested and must be authorized prior to being performed. **Charges for services that are not authorized, or which are provided in a facility other than which we have designated and approved for the transgender surgery requested, will not be considered *covered expense*.** See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

If the conditions for coverage listed below are met, this *plan* will provide *medically necessary* benefits in connection with transgender surgery.

CONDITIONS FOR COVERAGE

1. The *member* is at least 18 years old;
2. The *member* has criteria for the diagnosis of "true" transsexualism*;
3. The *member* has completed a recognized program at a specialized gender identity treatment center; and
4. The services are authorized (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details).

*The criteria and requirements are based on the guidelines stated in The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders. These guidelines may be modified from time to time. For a copy of the current guidelines, contact the *group* or Blue Cross Customer Service at the phone number of your I.D. card

TRANSGENDER SURGERY DEDUCTIBLES, CO-PAYMENTS AND MAXIMUMS

After we subtract any applicable Deductible and Co-Payment, we will pay benefits up to the amount of *covered expense,* not to exceed any applicable Transgender Surgery Maximum. The Deductible amounts, Co-Payments and Maximums are set forth in the SUMMARY OF BENEFITS.

CALENDAR YEAR DEDUCTIBLES

Each *year*, you will be responsible for satisfying the *member's* Calendar Year Deductible before we begin to pay benefits. If *members* of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all *family members* will be considered to have been met.

NOTE: The Calendar Year Deductibles for Medical Benefits and Transgender Surgery Benefits are combined. Any *covered expense* that applies toward one, applies toward the other. If you satisfy your *member* deductible under Transgender Surgery Benefits, the corresponding deductible for Medical Benefits is also satisfied.

CO-PAYMENTS

We will subtract your Co-Payment from the amount of *covered expense* remaining.

If your Co-Payment is a percentage, we will apply the applicable percentage to the amount of *covered expense*. This will determine the dollar amount of your Co-Payment.

The Transgender surgery Benefit Co-Payments are set forth in the SUMMARY OF BENEFITS.

TRANSGENDER SURGERY BENEFIT MAXIMUM

We do not make benefit payments for any *member* in excess of the Transgender Surgery Lifetime Maximum. Your Transgender Surgery Lifetime Maximum under this *plan* will be reduced by any Transgender Surgery Benefits we paid to you or on your behalf under any other health plan provided by Blue Cross, or any of its affiliates, which is sponsored by the *group*.

TRANSGENDER SURGERY CARE THAT IS COVERED

Subject to the Transgender Surgery Lifetime Maximum shown in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under TRANSGENDER SURGERY CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between us and the *hospital,* or unless your *physician* orders, and we authorize, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 240 days. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS: UTHORIZATION PROGRAM for information on how to obtain the proper reviews.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Transgender Surgery Travel Expense. The following travel expenses in connection with an authorized, transgender surgery performed at a facility which is designated by us and approved for the transgender surgery requested, provided the expenses are authorized by us (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.) for up to six trips:

a. Round trip coach airfare to the facility which is designated by us and approved for the transgender surgery requested, not to exceed **$250** per person per trip.
b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
c. Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.

TRANSGENDER SURGERY CARE THAT IS NOT COVERED

No payment will be made under Transgender Surgery Benefit of this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

In addition to the exclusions and limitations listed under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, benefits are not provided for or in connection with the following:

Not Authorized. Services or supplies that are not authorized (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details).

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined. For the purposes of this Transgender Surgery Benefit, if you meet the Conditions of Coverage (TRANSGENDER SURGERY BENEFITS: CONDITIONS OF COVERAGE), and the services and supplies for your transgender surgery are authorized by us (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details). This exclusion will not apply to those services and supplies we have authorized.

Excess Amounts. Any amounts in excess of *covered expense* or the Transgender Surgery Lifetime Maximum.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to transgender surgery.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *member* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.

    - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
    - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
    - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
    - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
    - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
    - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each *member,* per *calendar year,* and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as a *subscriber*.

For example: You are covered as a retired *subscriber* under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first and the plan which covers you as a retired *subscriber* will pay last, after Medicare.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *calendar year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

   a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

   b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

      i. The plan which covers that *child* as a dependent of the parent with custody.

      ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

      iii. The plan which covers that *child* as a dependent of the parent without custody.

      iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

   c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be

warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

Members will receive the full benefits of this *plan*, except for the following:

1. *Members* who are receiving treatment for end-stage renal disease following the first 30 months such *members* are entitled to end-stage renal disease benefits under Medicare; and
2. *Members* who are entitled to Medicare benefits as disabled persons; unless the *members* have a current employment status, as determined by Medicare rules, through a *group* of 100 or more employees (according to OBRA legislation).
3. Retired employees and the spouses of retired employees who are enrolled for Medicare Part A and/or Part B.

In the above cases, *plan* benefits will be based on Medicare allowance minus Medicare payment ($100 minus $80 = $20). *Plan* benefits are then applied to $20 (80% x $20 = $16). In this example, the *member's* responsibility is $4 ($20 minus $16).

Electronic Claims Coordination

If you are covered by Medicare, call us at the Blue Cross Customer Service unit at 1 (888) 209-7975 and tell us your Medicare number. We will load it to the Blue Cross membership system, which will permit us to electronically receive your Medicare EOB. This will allow us to generate your UC benefit without you having to submit a claim to us.

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to inpatient *hospital* admissions and outpatient surgery at an *ambulatory surgical center*. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: Medical management requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your *family members*.

UTILIZATION REVIEW PROGRAM

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if we have determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by us and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services*.*

It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of UTILIZATION REVIEW PROGRAM.

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays*; and
- Outpatient surgery at an *ambulatory surgical center*.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency inpatient *hospital* admissions and *ambulatory surgical center* services.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or we are notified while service is ongoing, for example, an emergency admission to the hospital.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* admission or an outpatient surgical procedure at an *ambulatory surgical center*, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate*,* benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed.

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call us directly. The toll-free number for Pre-authorization and pre-service review is printed on your identification card.

3. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. We will certify services that are *medically necessary* and appropriate. For inpatient *hospital* stays, we will, if appropriate, certify a specific length of *stay* for approved services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact us for concurrent review. For an *emergency* admission or procedure, we must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.

2. When participating providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.

3. When we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. We will also determine the medically appropriate setting.

4. If we determine that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your *physician* within two business days following our decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

***Extraordinary Circumstances.** In determining "extraordinary circumstances", we may take into account whether or not your condition was severe enough to prevent you from notifying us, or whether or not a member of your family was available to notify us for you. You may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

AUTHORIZATION PROGRAM

The authorization program provides prior authorization for medical care or service by a *non-participating provider,* and for certain "special services".

It is your responsibility to obtain authorization before you receive any service subject to the authorization program. The toll-free number to call for authorization is shown on your plan identification card.

If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of AUTHORIZATION PROGRAM.

SERVICES REQUIRING AUTHORIZATION

Authorized Referrals. In order for the maximum benefits of this *plan* to be payable, advance authorization is required for services received from *non-participating providers*. When the appropriate authorization is obtained, these services are called *authorized referral* services.

NOTE: *Authorized referrals* are not required for the services of *physicians* of a type not available within the Prudent Buyer Plan network. A *physician's* written referral is required, however, in order for the services of some *physicians* to be covered under this *plan*. Refer to the definition of "Physician" in the DEFINITIONS section.

Special Services

1. Organ and tissue transplants.
2. Transplant travel expense benefits.
3. Home health care.
4. Home infusion therapy.
5. Splint therapy services or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull.

6. Outpatient private duty nursing services.

7. Admissions to a *skilled nursing facility*.

8. Transgender Surgery Benefits services.

EFFECT ON BENEFITS

For Services Requiring Authorized Referral

1. The Co-Payment for *participating providers* will apply for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider*.

2. The Co-Payment for *non-participating providers* will apply for referral services received from *non-participating providers* that have not been authorized in advance.

For Special Services. When the appropriate authorization is not obtained, the benefits to which you would have been otherwise entitled **will be reduced by $200 for each occurrence. In addition, services for specified organ transplants are not covered when performed at other than a designated *COE*.**

WHEN AUTHORIZATION WILL BE PROVIDED

Authorized Referrals. Referrals to *non-participating providers* will be authorized only when all of the following criteria are met:

1. There is no *participating provider* who practices the appropriate specialty or provides the required services or has the necessary facilities within a 50-mile radius of your residence;

2. You are referred to the *non-participating provider* by a *physician* who is a *participating provider;* and

3. The services are authorized as *medically necessary* before services are received.

Special Services

1. **Organ and Tissue Transplants.** Authorizations for organ and tissue transplants will be provided as follows:

    a. For kidney, bone, skin or cornea transplants, only if both of the following criteria are met:

        i. The services are *medically necessary* and appropriate*;* and

        ii. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

    b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, only if all of the following criteria are met:

        i. The services are *medically necessary* and appropriate*;*

        ii. The providers of related preoperative and postoperative services are approved; and

        iii. The transplant will be performed at a *Center of Expertise (COE)*.

2. **Transplant Travel Expense Benefits.** Authorizations for transplant travel expense benefits will be provided for the recipient or donor only if all of the following criteria are met:

    a. It is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, authorized by us;

    b. The organ transplant must be performed at a specific *COE;* and

c. The specific *COE* is 250 miles or more from the recipient or donor's home.

3. **Home Infusion Therapy.** Authorizations for services by a *home infusion therapy provider* will be provided only if the following criteria are met:

   a. The services are *medically necessary* and appropriate*;* and

   b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services being rendered.

4. **Home Health Care.** Authorizations for home health care services will be provided only if the following criteria are met:

   a. The services are *medically necessary* and appropriate and can be safely provided in the *member's* home, as certified by the attending *physician*.

   b. The attending *physician* manages and directs the *member's* medical care at home.

   c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *member's* medical needs and must list the services to be provided by the *home health agency*.

5. **Temporomandibular Joint Disorders.** We will authorize splint therapy services or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull if the services are *medically necessary* and appropriate and likely to result in a significant improvement in your condition.

6. **Outpatient Private Duty Nursing Services.** We will authorize private duty nursing services of a licensed nurse (R.N., L.P.N. or L.V.N.) for care of a non-hospitalized acute illness or injury if the services are *medically necessary* and appropriate.

7. **Skilled Nursing Facility.** We will authorize inpatient services provided in a *skilled nursing facility* if:

   a. You require daily skilled nursing or rehabilitation, as certified by the attending *physician*;

   b. You are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and

   c. You will be treated for the same condition for which you were treated in the *hospital*.

8. **Transgender Surgery Benefits Services.** Authorizations for transgender surgery and related covered services will be provided as follows:

   a. The Surgical Procedure:

      i. You meet the Conditions for Coverage listed for the Transgender Surgery Benefits;

      ii. The services are *medically necessary* and appropriate*;* and

      iii. The *physicians* on the surgical team and the facility in which the surgery is to take place are approved for the transgender surgery requested.

   b. Transgender Surgery Travel Expense:

      i. It is for transgender surgery and related services, authorized by us;

      ii. The transgender surgery must be performed at a specific facility designated by us which is approved for the transgender surgery requested.

HOW TO OBTAIN AN AUTHORIZATION

For Authorized Referrals. You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

For Special Services Authorizations. You or your *physician* must call the toll-free telephone number printed on your identification card before the services are rendered.

THE MEDICAL NECESSITY REVIEW PROCESS

We work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, we are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 2 business days from receipt of the information necessary to make the decision.

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information necessary to make the decision.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision.

4. If we do not have the information we need, we will make every attempt to obtain that information from you or your *physician*. If we are unsuccessful, and a delay is anticipated, we will notify you and your *physician* of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service certified as *medically necessary* will be sent to you and your provider no later than 2 business days from the decision.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted telephonically for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

    - an explanation of the reason for the decision,
    - reference of the criteria used in the decision to modify or not certify the request,
    - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,

- how to request reconsideration if you or your provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables us to authorize you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. We have the right, through a case manager, to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive personal case management, nor do we have an obligation to provide it; we provide these services at our sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician, hospital* staff, or our claims reports. You or your family may also call us.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;

2. We anticipate that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;

3. Our cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and

4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with our recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If we determine that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this *plan*. A case manager will review the medical records and discuss your treatment with the attending *physician,* you, and your family.

We make treatment recommendations only; any decision regarding treatment belong to you and your *physician*. The *group* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward the Lifetime Maximum.

2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member,* which alternatives may be offered and the terms of the offer.

3. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *member*.

4. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member*.

Note: We reserve the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.

3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Medical management programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

EXTENSION OF BENEFITS

If you are a *totally disabled subscriber* or a *totally disabled family member* and under the treatment of a *physician* on the date of discontinuance of the *agreement*, your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.

2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.

3. Your extension of benefits will end when any one of the following circumstances occurs:

    a. You are no longer totally disabled.

    b. The maximum benefits available to you under this *plan* are paid.

    c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.

    d. A period of up to 12 months has passed since your extension began.

HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this *plan* ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your current employer's *plan*.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group *plan* ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program including Senior COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us and make the first premium payment within 63 days of the date your coverage under the employer's *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the *agreement* between the *group* and us terminates and is replaced by another group plan within 15 days.
2. You are not eligible if your coverage under this *plan* ends because subscription charges are not paid when due because you (or the *subscriber* who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

   The three-month period of coverage requirement does not apply to a *member* who has been covered under another UC plan then switches to this *plan* during Open Enrollment and needs to convert prior to being covered for three consecutive months under this *plan*.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

Important: The intention of conversion coverage is not to replace the coverage you have under this *plan,* but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

When coverage under your employer's group *plan* ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

CERTIFICATION OF CREDITABLE COVERAGE

In accordance with the statutory requirements of the Health Insurance Portability and Accountability Act of 1996 and Section 1357.51 of the California Health and Safety Code, we will provide certifications of periods of creditable coverage for *members* whose coverage under the *plan* terminates.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of *hospital,* medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. Our relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital,* medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which we are a member, has a program (called the "BlueCard Program") which allows our *members* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, we must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your co-payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, the "negotiated price," referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *member* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *member* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement,* both the *agreement* and your coverage under the *agreement* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your subscription charges are paid according to the terms of the *agreement*.

Free Choice of Provider. This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan,* and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Continuity of Care. If we terminate our contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling us at the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from us, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the subscription charge paid for you. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this *plan*.

Medical Necessity. The benefits of this *plan* are provided only for services which are considered to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. We will pay the benefits of this *plan* directly to *participating providers*, *COE* and medical transportation providers. Also, we will pay other providers of service directly when you assign benefits in writing. If you are a MediCal beneficiary and you assign benefits in writing to the

State Department of Health Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator - COBRA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers either to the *group* or to a person or entity other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Workers' Compensation Insurance. The *agreement* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* or *other health care provider* any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You may be liable, however, to pay *non-participating providers* any amounts not paid to them by us.

Renewal Provisions. Your employer's health plan *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Financial Arrangements with Providers. Blue Cross or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its *subscribers* and *members*/insured persons entitled to health care benefits under individual certificates and group policies or contracts to which Blue Cross or an affiliate is a party, including all persons covered under the *agreement*.

Under the above-referenced contracts between Providers and Blue Cross or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *agreement* may differ from the rates paid for persons covered by other types of products or programs offered by Blue Cross or an affiliate for the same medical services. In negotiating the terms of the *agreement*, the *group* was aware that Blue Cross or its affiliates offer several types of products and programs. The *subscribers*, *family members* and the *group* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically applicable to Blue Cross or its affiliates' agreements for insured group accounts.

Under arrangements with some health care providers and suppliers (hereafter referred to together as "Providers") certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, may be based on aggregate payments made by Blue Cross or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Blue Cross or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Blue Cross or an affiliate in determining its fees or subscription charges or premiums.

Confidentiality and Release of Medical Information. We will use reasonable efforts, and take the same care to preserve the confidentiality of the *member's* medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the *member*. Medical information may be released only with the written consent of the *member* or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. *Members* may access their own medical records.

We may release your medical information to professional peer review organizations and to the *group* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *group* to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Medical Policy and Technology Assessment. Blue Cross reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Blue Cross' medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Blue Cross' medical directors, physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *agreement* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The *member* and Blue Cross agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

The *member* and Blue Cross agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *member* waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross waives any right to pursue on a class basis any such controversy or claim against the *member*.

The arbitration findings will be final and binding except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the *member* making written demand on Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *member* and Blue Cross, or by order of the court, if the *member* and Blue Cross cannot agree. The arbitration shall be held in the State of California.

Blue Cross and the *member* will each be responsible for paying their own shares of the fees and expenses of the arbitration; however, we may pay the *member's* share of these fees in cases of extreme hardship, as determined by JAMS. An application to claim extreme hardship under this section may be obtained from JAMS.

DEFINITIONS

The meanings of key terms used in this booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this booklet, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Agreement is the Group Benefit Agreement issued by us to the *group*.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, are referred to a *non-participating provider,* but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;

2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider,* and

3. We have authorized the referral before services are rendered.

Blue Cross of California (Blue Cross) is a health care service plan, regulated by the California Department of Managed Health Care.

Centers of Expertise (COE) are health care providers which have a Centers of Expertise Agreement in effect with us at the time services are rendered. COE agree to accept the *COE negotiated rate* as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a COE. A provider's participation in the Prudent Buyer Plan network or other agreement with us is not a substitute for a Centers of Expertise Agreement.

Centers of Expertise negotiated rate (COE negotiated rate) is the fee *COE* agree to accept as payment for covered services. It is usually lower than their normal charge. COE negotiated rates are determined by Centers of Expertise Agreements.

Child meets the *plan's* eligibility requirements for children outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under a publicly sponsored program such as Medicare or Medicaid, CHAMPUS, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, or coverage through the Peace Corps. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

You are considered to have been covered under a creditable coverage if you: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *plan* within 63 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

You are also considered to have been covered under a creditable coverage if your employment ended, the availability of medical coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward medical coverage terminated, provided that you: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *plan* within 180 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by us, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *member* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with us.

Emergency services are services provided in connection with the initial treatment of a medical *emergency*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Family member meets the *plan's* eligibility requirements for family members outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is UNIVERSITY OF CALIFORNIA.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically necessary procedures, supplies equipment or services are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the *subscriber* or *family member*.

Mental or nervous disorders, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (*e.g.*, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare's approved amount (see HOW COVERED EXPENSE IS DETERMINED).

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

1. A *hospital;*

2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

1. A *hospital;*
2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8 A clinical laboratory; or
9 A *home infusion therapy provider*.

Participating providers agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:

    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist
    f. A chiropractor (D.C.)
    g. An acupuncturist (A.C.)

h. A clinical social worker (L.C.S.W.)
i. A marriage and family therapist (M.F.T.)
j. A physical therapist (P.T. or R.P.T.)*
k. A speech pathologist*
l. An audiologist*
m. An occupational therapist (O.T.R.)*
n. A respiratory care practitioner (R.C.P.)*
o. A psychiatric mental health nurse (R.N.)*
p. A nurse midwife**
q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the *agreement* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change.

Prior plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Reasonable charge is a charge we consider not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Severe mental disorders include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse meets the *plan's* eligibility requirements for spouses outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Subscriber is the person who, by meeting the *plan's* eligibility requirements for subscribers, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*. Such requirements are outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Totally disabled family member is a *family member* who is unable to perform all activities usual for persons of that age.

Totally disabled retired employee a retired employee who is unable to perform all activities usual for persons of that age.

We (us, our) refers to Blue Cross of California.

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *subscriber* and *family members* who are enrolled for benefits under this *plan*.

GRIEVANCE PROCEDURES

If you have a question about your eligibility, your benefits under this *plan*, or concerning a claim, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card). Our customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the customer service representative. You may complete and return the form to us, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Blue Cross of California website at **www.bluecrossca.com/uc**. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. After we have reviewed your grievance, we will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days, you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care for review.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy is binding arbitration (see BINDING ARBITRATION).

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. To request an application form, please call us at the telephone number listed on your identification card or write to us at Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
    - ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
    - ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The proposed treatment must be recommended by either (a) a *participating provider* or (b) a board certified or board eligible *physician* qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.

- If this review is requested either by you or by a qualified *non-participating provider* (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:

    a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;

    b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;

    c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

    d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

    e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

    f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Information we receive subsequently will be sent to the review panel within three business days. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your *plan* that has been denied, modified, or delayed by us, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:

    (a) Your provider has recommended a health care service as *medically necessary*,

    (b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

(c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not *medically necessary*; and

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is *medically necessary*. You will receive a copy of the assessment made in your case. If the IMR determines the service is *medically necessary*, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 business days.

For more information regarding the IMR process, or to request an application form, please call us at the customer service telephone number listed on your ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

FOR YOUR INFORMATION

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling 1 (888) 209-7975, printed on your identification card, or on the Blue Cross of California web site at **www.bluecrossca.com/uc**. To access network provider benefit information, claims payment status, benefit maximum status, or to order an ID card, simply log on to the web site. You may also submit a grievance online or print the Plan Grievance form through the website. Access to the "Member Services" segment of the website requires a PIN. If you do not have a Personal Identification Number (PIN) from Blue Cross, you can request one at this page and it will be sent to you within seven (7) business days.

MedCall

Your *plan* includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call MedCall toll free at **800-977-0027**, be prepared to provide your name, the patient's name (if you're not calling for yourself), the *subscriber's* identification number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs. Based on the information you provide, the advice may be:

- Home self-care. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your *physician*. If you do not have a *physician,* the nurse will help you select one by providing a list of *physicians* who are *participating providers* in your geographical area.
- Call your *physician* for further discussion and assessment.
- To go to an emergency room in a *participating provider hospital*.
- Instructions to immediately call 911.

In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimited access to its Audio Health Library featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free 800-977-0027 and follow the instructions given.

We have made arrangements with an independent company to make MedCall available to you as a special service. It may be discontinued without notice.

Note: MedCall is an optional service. Remember, the best place to go for medical care is your *physician.*

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IMPORTANT INFORMATION ABOUT YOUR MENTAL HEALTH BENEFITS

Benefits for certain *severe mental disorders* and serious emotional disturbances of a child are provided by United Behavioral Health (the BHP), a health care service plan licensed by the California Department of Managed Health Care (the "DMHC"), through a direct arrangement with the *group*. Benefits are provided at the same level, including any deductibles and copayments, as we provide for all other medical conditions. If you believe that United Behavioral Health is not providing these services according to these guidelines, please contact us at the telephone number listed on your ID card and the DMHC as described in this booklet under "Department of Managed Health Care".