



UNIVERSITY OF CALIFORNIA

Effective January 1, 2013

Retirees with Medicare

CERTIFICATE OF INSURANCE

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, California 91367

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your health plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Agreement, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Certificate of Insurance that apply to those needs. Your employer will provide you with a copy of the Group Agreement upon request.

Your health care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your health care benefits and include the limitations and all other *agreement* provisions which apply to you. The *member* is referred to as "you" or "your," and Anthem Blue Cross Life and Health as "we," "us" or "our." All italicized words have specific *agreement* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

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UNIVERSITY OF CALIFORNIA

RETIREES WITH MEDICARE

BENEFITS AT A GLANCE

Please Note: this medical plan is a complement to your existing Medicare plan. Medicare benefits are primary and then the benefits of this plan are calculated on Medicare allowance, less Medicare payment. Benefits not covered by Medicare, but covered by the Plan will be reimbursed at 80% of customary and reasonable charges.

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 Certificate of Insurance.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance.

Members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Members are also responsible for all costs over the plan maximums. Important information appears in *italics*.

Explanation of Covered Expense

When an expense is covered by Medicare, the Medicare allowable is the covered expense. When an expense is not covered by Medicare, plan payments apply to the lesser of the charges billed by the provider or the customary & reasonable charge for professional services or the reasonable charge for institutional services. Members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar Year Deductible	\$100/member/Medical Benefits \$250/member/Transgender Surgery Benefits
Non-Certification Deductible when preauthorization is not obtained	\$200/occurrence
Annual Out-of-Pocket Maximums	\$1,500/member/year
The following do not apply to out-of-pocket maximums: non-covered expense, non-compliance penalty charges, charges in excess of covered expense, and expenses for non-compliance with Medicare rules. After a member reaches the out-of-pocket maximum, the member no longer pays copays for the remainder of the year. The member, however, remains responsible for non-covered expense, costs in excess of the covered expense and penalties for non-compliance with Medicare rules.	
Lifetime Maximum	Unlimited
Covered Services	Per Member Copay
Hospital Medical Services (<i>preauthorization required for non-emergency admissions</i>) & ancillary services	
➤ Semi-private room, meals & special diets, and ancillary services	20%
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	20%
Ambulatory Surgical Centers	
➤ Outpatient surgery, services & supplies (<i>Benefit limited to \$350/admit when seeking care from a non-participating Medicare provider</i>)	20%
Skilled Nursing Facility (<i>preauthorization required</i>)	
➤ Semi-private room, services & supplies (<i>limited to 240 days/calendar year</i>)	20%

Covered Services	Per Member Copay
Hospice Care	
➤ Inpatient or outpatient services	20%
Home Health Care (<i>preauthorization required</i>)	
➤ Services & supplies from a home health agency (<i>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</i>)	20%
Home Infusion Therapy (<i>preauthorization required</i>)	
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%
Outpatient Private Duty Nursing (<i>preauthorization required: limited to \$10,000/ calendar year</i>)	
	20%
Physician Medical Services	
➤ Office & home visits	20%
➤ Hospital & skilled nursing facility visits	20%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%
➤ Telemedicine Program*	20%
<i>*Benefits provided through Anthem Blue Cross' Telemedicine Network.</i>	
Diagnostic X-ray & Lab (<i>including mammograms, pap smears, prostate cancer & colon screening tests including, sigmoidoscopy & colonoscopy, and other cancer screening tests</i>)	
	20%
Radiation Therapy, Chemotherapy & Hemodialysis Treatment	
	20%
Preventive Care (<i>preventive care services that meet the requirements of federal & state law</i>)	
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam (<i>deductible waived</i>)	No copay
➤ Vision Exams (<i>deductible waived</i>)	No copay
➤ Hearing Exams (<i>deductible waived</i>)	No copay
➤ Hearing Aids (<i>maximum of 1 hearing aid per ear every 36 months, analog and digital devices are covered</i>)	20%
➤ Allergy testing & treatment (<i>including serums</i>)	20%
Physical Therapy, Physical Medicine & Occupational Therapy	
	20%
Chiropractic Services	
	20%
Speech Therapy	
➤ Outpatient speech therapy following injury, illness or other medical condition, as <i>medically necessary</i>	20%
Acupuncture	
➤ Services for the treatment of disease, illness or injury	20%
Temporomandibular Joint Disorders (<i>preauthorization required</i>)	
➤ Splint therapy & surgical treatment	20%
Family Planning Services	
➤ Infertility studies & tests	20%
➤ Tubal ligation	20%
➤ Vasectomy	20%
➤ Counseling & consultation	20%
➤ Elective abortion	20%

Covered Services	Per Member Copay
Pregnancy & Maternity Care	
➤ Physician office visits (<i>deductible waived</i>)	20%
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	20%
Normal delivery, cesarean section, abortion (<i>newborn routine nursery care covered</i>)	
➤ Inpatient physician services	20%
➤ Hospital & ancillary services	20%
Organ & Tissue Transplants (<i>preauthorization required</i>)	
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%
➤ Physician office visits (<i>including specialists and consultants</i>)	20%
➤ Transplant travel expense for an authorized, specified transplant at an approved transplant center (<i>recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days</i>)	No copay (<i>deductible waived</i>)
Diabetes Education Programs (<i>requires physician supervision</i>)	
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%
Prosthetic & Orthotic Devices	
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & <i>medically necessary</i> therapeutic shoes & inserts	20%
Durable Medical Equipment	
➤ Rental or purchase of DME including dialysis equipment & supplies	20%
Related Outpatient Medical Services & Supplies	
➤ Ground or air ambulance transportation, services & disposable supplies	20%
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%
➤ Autologous blood (<i>self-donated blood collection, testing, processing & storage for planned surgery</i> ;	20%
Emergency Care	
➤ Emergency room services & supplies	20%
➤ Inpatient hospital services & supplies	20%
➤ Ambulatory surgical center services & supplies	20%
➤ Physician services	20%

Covered Services	Per Member Copay
Transgender Surgery* (<i>\$100 CY deductible applies</i>)	
➤ Hospital - inpatient & outpatient services & supplies	20%
➤ Physician services, including specialists	20%
➤ Anesthetist	20%
➤ Skilled nursing facility services	20%
➤ Rehabilitative care services	20%
➤ Transgender surgery travel expense (<i>deductible waived</i>) 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	No copay
➤ Transgender Surgery Lifetime Maximum: \$75,000	
<i>*Benefits provided through authorized Transgender Surgery physicians only.</i>	

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

The benefits provided in this summary are subject to federal and California laws. In addition to the benefits described above, coverage may include additional benefits required by the member's state of residence.

Members traveling out of the country will be responsible for 20% of the billed charges.

UNIVERSITY OF CALIFORNIA
ELIGIBILITY, ENROLLMENT, TERMINATION AND
PLAN ADMINISTRATION PROVISIONS

January 1, 2013

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

Individuals are eligible to enroll in this Plan are described below, except that if the Plan is a Point of Service (POS) Plan, only those individuals who meet the Plan's geographic service area criteria may enroll. 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 disenrolled from this health plan (not applicable to members of the Anthem Blue Cross PPO Medicare without Prescription Drug 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 defined benefit plan to which the University contributes.

You may be eligible for University medical plan coverage as a Retiree provided that you meet the following requirements:

- (a) You meet the University's service credit requirements for Retiree medical eligibility;
- (b) You elect to receive your retirement benefits in the form of monthly payments;
- (c) The effective date of your retirement is within 120 calendar days of the date your University employment ends; and
- (d) You elect to continue (or suspend) medical coverage prior to the effective date of your retirement.

For more information, see the *UC Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

UCRP Disabled Member: If you are approved for Disability Income from the University of California Retirement Plan (UCRP), you may be eligible to continue your University medical plan coverage after you separate from University employment, provided you were enrolled in medical coverage when you separated, your coverage is continuous until your Disability Income begins, and you meet any other University coverage requirements.

For more information, see the *University of California Retirement Plan Disability Handbook*.

Survivor: If you are a surviving Family Member of a deceased Employee or Retiree, and you are receiving monthly benefits from a defined benefit plan to which the University contributes, you may be eligible to receive medical coverage as set forth in the University's Group Insurance Regulations. (**Note:** Survivors receiving University-sponsored medical coverage may NOT enroll a spouse or domestic partner for coverage as a Family Member.)

For more information, see the applicable *Survivor and Beneficiary Handbook*.

Medicare Eligible: If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Enrollment" below.

Eligible Family Members

When you enroll any individual(s) in the Plan as a Family Member, you must provide documentation specified by the University verifying that the individual(s) you have enrolled meet(s) the eligibility requirements outlined below. The Plan may also require documentation verifying eligibility status. In addition, the University and/or the Plan reserves the right to periodically request documentation to verify the continued eligibility of enrolled Family Members.

Eligible Adult: You may enroll one eligible adult Family Member, in addition to yourself:

Spouse: Your legal spouse.

Domestic Partner: You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age.

NOTE: An adult dependent relative is not eligible for coverage in UC plans ***unless enrolled prior to December 31, 2003 and continuously eligible and enrolled since that date***. To review the ongoing eligibility requirements for enrolled adult dependent relatives, see the *Group Insurance Eligibility Factsheet for Employees and Eligible Family Members* or the *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

Also, remember: If your eligible adult dependent relative is still enrolled in the Plan, you cannot also enroll your spouse or domestic partner.

Child: All eligible children must be under the limiting age of 26 (18 for legal wards) except for a child who is incapable of self support due to a mental or physical disability. The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your spouse's natural or legally adopted children (your stepchildren);
- (c) your eligible domestic partner's natural or legally adopted children;
- (d) grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
- (e) children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

- (f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

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 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you, your spouse, or your eligible domestic partner for support and maintenance (50% or more); and
- the child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, 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.

Except as provided below, application for coverage beyond age 26 due to disability must be made to the Plan 60 days prior to the date coverage is to end due to reaching limiting age. If application is received timely but the Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending the Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled 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; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage, adoption or domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee or Retiree. See *At Your Service* online for related information. Contact your tax advisor for additional information.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Disabled Member, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible for coverage, each may enroll separately or one may enroll and 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 the person who handles benefits for your location or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: <http://atyourservice.ucop.edu>.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, contact the person who handles benefits for your location. If you are a Retiree or a surviving Family Member, contact the UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice, during a Period of Initial Eligibility (PIE), which may occur when you first become eligible or when you have another enrollment opportunity.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under “Special Circumstances” paragraph 1.d below). Also see “At Other Times for Employees and Retirees” below. Electronic enrollment transactions must be completed online by the last day of the applicable PIE. Paper enrollment forms must be received at the location specified on the form by the last day of the applicable PIE, except that if the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day.

Employee

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.

Retiree

If you are a Retiree who is eligible for Retiree medical coverage, keep in mind that retirement alone does not entitle you to a PIE to change your medical plan or to enroll yourself and/or your eligible Family Members in medical plan coverage.

If you and any eligible Family Members were enrolled in a University-sponsored medical plan immediately before your retirement, and you are eligible for Retiree medical, you may continue coverage in that plan (or, if applicable, its Medicare version upon completion of Medicare assignment) for yourself and your enrolled Family Members; you may change plans and/or add eligible Family Members during the University’s next open enrollment period or at certain other times, as described below (See “At Other Times for Employees and Retirees”).

If you are eligible for Retiree medical coverage when you retire, but you are enrolled, or enroll, in non-University sponsored medical coverage at that time (e.g., medical coverage provided by your spouse’s or domestic partner’s employer), you may elect to suspend your Retiree coverage.

You must elect to continue or suspend enrollment before the effective date of your retirement. For more information, see the *UC Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

Similar rules apply to **Survivors**. For more information, see the *Survivor and Beneficiary Handbook*.

Family Members

A newly eligible Family Member’s PIE starts the day he or she becomes eligible, as described below. During this PIE, you may enroll the newly eligible Family Member as well as yourself and/or any other eligible Family Member(s) if not already enrolled. If you are already enrolled in this Plan, you may add your current and newly eligible Family Member(s) to the Plan or you may enroll yourself and all eligible Family Members in a different University-sponsored plan. However, you must enroll yourself in order to enroll any eligible Family Members, and you and all eligible Family Members must be enrolled in the same plan.

Note: If you are a Survivor receiving University-sponsored medical coverage, you may NOT enroll a spouse or domestic partner for coverage as a Family Member.

Family Member Eligibility Dates

- (a) For a spouse, on the date of marriage.
- (b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see “At Other Times for Employees and Retirees” below.

- (c) For a natural child, on the child's date of birth.
- (d) For an adopted child, the earlier of:
 - (i) the date the child is placed for adoption with the Employee/Retiree, or
 - (ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

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.

- (e) For a legal ward, the effective date of the legal guardianship.
- (f) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Point of Service (POS) 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 the time period specified under the terms of the Plan, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. If you return to your original location, and the plan providing coverage prior to your return is not available in that location, you will again have a PIE to enroll in any University medical plan. Otherwise, you may change plans during the University's next open enrollment period or at certain other times, as described below under "At Other Times for Employees and Retirees."

At Other Times for Employees and Retirees

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

90-Day Waiting Period. If you are an Employee and miss an opportunity 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, unless one of the **Special Circumstances** described below applies.

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, unless one of the **Special Circumstances** described below applies.

The 90-day waiting period starts on the date the completed enrollment form is received at the location specified on the form and ends 90 consecutive calendar days later.

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

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).
 - b. You stated at the time you became eligible for coverage under a University-sponsored Plan that you were opting out or if applicable, suspending, coverage under this Plan because you were covered under another health plan as stated above.

- c. Coverage under another health plan for you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, coverage under COBRA or CalCOBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.
 - d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**
2. You or your eligible Family Members are not currently enrolled in UC-sponsored medical coverage and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.
 3. A court has ordered coverage be provided for a dependent child under your UC-sponsored medical plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.
 4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
 - a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.
 5. For Employees, you and/or an eligible Family Member experiences an event not otherwise covered by paragraphs 1 through 4, above, that would permit enrollment under the terms of the University of California Tax-Savings on Insurance Premiums Plan and Section 125 of the Internal Revenue Code. For more information on permitted change events, see the *Tax Savings on Insurance Premiums (TIP) Summary Plan Description*.

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 completed enrollment form is received, unless the enrollee is Medicare-eligible. Coverage for Medicare-eligible enrollees will be effective as of the first of the month following the end of the 90-day waiting period.

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:

- (a) the date the Child becomes eligible, or

- (b) a maximum of 60 days prior to the date your Child's enrollment form is received by the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Effect of Medicare on Enrollment

Except as provided below, if you are a Retiree or Survivor and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then you and/or your Family Member must also enroll in and remain in Medicare Part B (Medical Insurance). **This includes individuals eligible for Medicare benefits through their own or their spouse's employment. If an individual (Retiree or Family Member) fails to enroll at the earliest opportunity, he or she will still be required to do so even if a Medicare late enrollment penalty applies.**

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

Retirees or Survivors 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 and continue Part B will permanently lose their UC-sponsored medical coverage.

Retirees or Survivors and their Family Members who were eligible for premium-free Medicare Part A between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Survivors 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 if they remain ineligible to enroll based on their own or their spouse's employment. Documentation attesting to their ineligibility for Medicare Part A will be required.

An exception to the above rules applies to Retirees or Survivors 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.

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 University that you are covered by Part A and Part B of Medicare. The University's *Medicare Declaration* form is available through the UC Customer Service Center or from the web site: <http://atyourservice.ucop.edu>. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be disenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan (not applicable to members of the Anthem Blue Cross PPO Medicare Without Prescription Drug Plan).

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and a large employer group health plan. Employees or their opposite-sex spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to the MSP rules. Under those rules, Medicare becomes the secondary payer and the employer plan becomes the primary payer. The MSP rules do not apply to an Employee's or Retiree's same-sex spouse or domestic partner, age 65 or over, who is covered as a Family Member under a University-sponsored plan. Medicare is primary for those individuals.

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.

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 month in which eligibility status is lost. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for a HIPAA individual plan or a conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your monthly retirement payments terminate, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

Also, if you are enrolled in a medical plan that requires premium payments (in addition to amounts subtracted from your monthly retirement payments), and you do not continue payment, your coverage will be terminated at the end of the month for which you paid.

If your Family Member loses eligibility, and you wish to make a permitted change in your health or flexible spending account coverage, you must complete the appropriate transaction to delete him or her within 31 days of the eligibility loss event, although for purposes of COBRA eligibility, notice may be provided to UC within 60 days of the family member's loss of coverage. For information on deenrollment procedures, contact the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Other Deenrollments

Coverage for you and/or your Family Members may be suspended for up to 12 months if you and/or a Family Member misuse the Plan, as described in the Group Insurance Regulations. Misuse includes, but is not limited to, actions such as falsifying enrollment or claims information, allowing others to use the Plan identification card, intentionally enrolling, or failing to deenroll, individuals who are not/no longer eligible Family Members, threats or abusive behavior toward Plan providers or representatives. You may also be deenrolled for up to 12 months if you fail to provide upon request documentation specified by the University or the Plan verifying that the individual(s) you have enrolled are eligible Family Members. Individuals whose eligibility has not been verified will be deenrolled until verification is provided. Individuals who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

Contact the person who handles benefits for your location for information about continuing your coverage in the event of an authorized leave of absence, layoff, change of employment status, or retirement.

Optional Continuation of Coverage

As an enrollee in this Plan you and/or your covered Family Members may be entitled to continue health care coverage if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your Family Members will have to pay for such coverage. You may direct questions about these provisions the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor) or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html.

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits incurred after the contract terminates. You may be entitled to continued benefits under terms which are specified elsewhere in this document . (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

PLAN SPONSORSHIP AND PLAN AND CLAIMS ADMINISTRATION

Plan Sponsor and Plan Administrator

The University of California is the Plan Sponsor and the President of the University (or his/her delegates) is the Plan Administrator for the Plan eligibility and enrollment provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Any appeals regarding coverage denials that relate to eligibility or enrollment requirements are subject to the University of California Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Claims Administrator

Claims and appeals for benefits under the Plan are processed by Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health has full and final discretion and authority to determine whether and to what extent enrollees are entitled to benefits under the Plan. If you have a question about benefits under the Plan or about a specific claim, please refer to the appeal section found later in this document and/or contact Anthem Blue Cross Life and Health at the following address and phone number:

Anthem Blue Cross Life and Health
21555 Oxnard Street
Woodland Hills, CA 91367
(888) 209-7975

This Plan is administered in accordance with the University of California Group Insurance Regulations, applicable contracts/service agreements, evidence of coverage booklets, and applicable 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 Plan Administrator or Claims Administrator, as applicable. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the group insurance contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received.

Group Contract Number

The Group Contract Number for this Plan is: 175011

Type of Plan

This plan provides group medical care benefits. This plan is one of the benefit plans offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

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 indefinitely but reserves the right to terminate or amend the benefits provided under this or any University-sponsored plan at any time. Plan benefits are not accrued or vested benefit entitlements. Any such amendment or termination shall be carried out by the President or his or her delegates. 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 Anthem Blue Cross Life and Health under a Group Service Agreement.

The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Anthem Blue Cross Life and Health at the address listed above.

Your Rights under the Plan

As a participant in a University of California 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 Service 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.

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 Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607, and for faculty to the Office of Academic Personnel, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

SUMMARY OF BENEFITS

THE BENEFITS DESCRIBED IN THIS CERTIFICATE SUPPLEMENT MEDICARE BENEFITS AS WELL AS EXPENSE NOT COVERED BY MEDICARE FOR SERVICES THAT ARE 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.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

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*.

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 testing; 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.

Care After Hours. If you need care after your *physician's* normal office hours and you do not have an *emergency* medical condition or need *urgent care*, please call your *physician's* office for instructions.

All benefits are subject to coordination with benefits under certain other plans, and may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL BENEFITS

UTILIZATION REVIEW PROGRAM REQUIREMENTS -- Your *plan* has UTILIZATION REVIEW PROGRAM requirements. These are explained in the UTILIZATION REVIEW PROGRAM section beginning on page 48. **Your benefits may be reduced** if you do not follow the procedures outlined. If you have any questions about the UTILIZATION REVIEW PROGRAM requirements, call us at the toll-free number on your identification card.

EMERGENCY CARE -- If you are admitted to the hospital in an emergency or have experienced an emergency medical procedure, call Anthem Blue Cross Life and Health immediately using the number on your ID card or call 888-209-7975.

For an *emergency* admission or procedure, we must be notified within one working day of the admission or procedure. Failure to notify us of such care may result in your benefits being denied or reduced. Please refer to the section entitled UTILIZATION REVIEW PROGRAM, beginning on page 48, for details.

Please read the definition of "Emergency" in the DEFINITIONS section carefully. This definition will be strictly enforced.

DISPUTES/APPEALS -- The Agent for Service of Legal Process is Anthem Blue Cross Life and Health Insurance Company. Provisions describing the process for member disputes, complaints, and requests for review of denied claims can be found under the sections "INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT", "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE" and "BINDING ARBITRATION". See pages 61-64 for details.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductible..... **\$100**
per member

Exceptions: The Calendar Year Deductible will not apply to the following services:

- Well Baby and Well Child Care services.
- Services for screening for blood lead levels in children at risk for lead poisoning.
- Physical Exam services.
- Adult Preventive Services.
- Office visits for pregnancy or maternity care.
- Transplant travel expenses authorized by us. Transplant travel expense is available when the closest approved transplant facility is more than 250 miles from the recipient or donor's residence. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.

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

Exception: The Non-Certification Deductible will not apply to *emergency* admissions. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS AND OUT-OF-POCKET AMOUNT

Co-Payments. After you have met your Calendar Year Deductible, if applicable, you will be responsible for **20%** of *covered expense* you incur, plus any amount in excess of *covered expense*.

Exceptions:

- You are not required to make Co-Payment for services covered under the Well Baby and Well Child Care benefit. However, you remain responsible for any amount in excess of *covered expense*.
- You are not required to make a Co-Payment for any covered services under the Screening for Blood Lead Levels benefit.
- You are not required to make Co-Payment for services of a *physician* for services covered under the Physical Exam benefit. However, you remain responsible for any amount in excess of *covered expense*.
- You are not required to make Co-Payment for services of a *physician* for services covered under the Adult Preventive Services benefit. However, you remain responsible for any amount in excess of *covered expense*.
- No Co-Payment will be required for the transplant travel expenses authorized by us. See UTILIZATION REVIEW PROGRAM.

Out-of-Pocket Amount. After you have **\$1,500** in total out-of-pocket payments (including the Calendar Year Deductible) 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*

Exceptions:

- 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 is always your responsibility.

- UTILIZATION REVIEW PROGRAM penalties will not be applied toward your Out-of-Pocket Amount and are always your responsibility.
- Co-Payments made for services covered through **United Behavioral Health**, your mental health care benefits carrier, will also be applied toward the satisfaction of your Out-of-Pocket Amount under this *plan*.

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

Ambulatory Surgical Center

- For all covered services and supplies **\$350**
per admission*

*benefit limited when seeking care from a non-participating Medicare provider

Outpatient Private Duty Nursing

- For covered private duty nursing services..... **\$10,000**
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 transplant center..... **\$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 other reasonable expenses (excluding
meals, tobacco, alcohol and drug expenses) **\$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 transplant center..... **\$250**
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 7 days
 - For other reasonable expenses (excluding
meals, tobacco, alcohol and drug expenses) **\$25**
per day, up to 7 days

Hearing Aids

- For covered charges..... **1 hearing aid**
per ear every thirty-six (36) month period

Overall Medical Lifetime Maximum

- For all medical benefits..... **Unlimited**

Members traveling out of the country will be responsible for 20% of the billed charges.

TRANSGENDER SURGERY BENEFITS

CALENDAR YEAR DEDUCTIBLE*

Member Deductible **\$100**

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

***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

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%**

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.

Type of Provider. The maximum *covered expense* for services provided by a *physician* will be the lesser of the billed charge or the *customary and reasonable charge*. The maximum *covered expense* for services provided by a *hospital* or *other health care provider* will be the lesser of the billed charge or the *reasonable charge*.

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* or *other health care provider*, in excess of the lesser of the maximum *covered expense* stated above, or:
 - a. For *providers* who accept Medicare assignment, the approved amount as determined by Medicare; or
 - b. For *providers* who do not accept Medicare assignment, 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 AMOUNT AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable deductible and your Co-Payment, benefits will be paid up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-of-Pocket Amount 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 Deductible. Each *year*, you will be responsible for satisfying the Calendar Year Deductible before the *plan* begins to pay benefits.

Non-Certification Deductible. Each time you are admitted to a *hospital* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission. Certification is explained in 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. 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 AMOUNT

Satisfaction of the Out-of-Pocket Amount. If the Co-Payments you paid, together with the Calendar Year Deductible you satisfied, equal your Out-of-Pocket Amount per *member* 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*.

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:

- Utilization Review Program penalties that may apply;
- Expense which is incurred for non-covered services or supplies; and
- Expense which is in excess of the amount of *covered expense*.

NOTE: Co-Payments made for services covered through **United Behavioral Health**, your mental health care benefits carrier, will also be applied toward the satisfaction of your Out-of-Pocket Amount under this *plan*.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums.

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 under 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 under 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:

Urgent Care. Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not *emergency services*. Services for urgent care are typically provided by an *urgent care center* or other facility such as a physician's office.

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*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

Hospital services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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 pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM 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 pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

If you have a terminal illness and a life expectancy of one year or less, you have the option of electing Hospice Care benefits, which include professional services of an attending *physician*. An attending *physician* is one who is identified by you at the time you elect Hospice Care benefits as having the most significant role in the determination and delivery of your medical care. If you elect to receive Hospice Care, you must file an election statement with the *hospice*. You may revoke the election at any time. Election and revocation statements are available through the *hospice*.

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, 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. Medical direction with the medical director also responsible for meeting your general medical needs to the extent they are not met by your *physician*.
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); but 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 UTILIZATION REVIEW PROGRAM for details.

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

Our maximum payment is limited to **\$350** per admission when seeking care from a non-participating Medicare provider.

Professional Services

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

Outpatient Private Duty Nursing. We will pay up to **\$10,000** per *calendar year* for 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, 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 UTILIZATION REVIEW PROGRAM 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.

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. This includes *medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Ambulance. We will pay for 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 radiology and laboratory services.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic and Orthotic 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;
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
 - d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
 - e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. 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 procedure.

Pregnancy and Maternity Care

1. All medical benefits for a *member* when provided for pregnancy or maternity care, including the following services:
 - a. Prenatal and postnatal care;
 - b. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);
 - c. Involuntary complications of pregnancy;
 - d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
 - e. Inpatient *hospital* care including labor and delivery.

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. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is a *member*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

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 *ambulatory 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*.
4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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 a *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 UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense. The following travel expenses in connection with an approved, 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) when the recipient or donor's home is more than 250 miles from the transplant facility, provided the expenses are approved by us in advance:

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
 - a. Round trip coach airfare to the transplant facility, 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 reasonable expenses, excluding meals, tobacco, alcohol and other drug expenses, 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 transplant facility, not to exceed **\$250**.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 7 days.

- c. Other reasonable expenses, excluding meals, tobacco, alcohol and drug expenses, not to exceed **\$25** per day, for up to 7 days.

Well Baby and Well Child Care. We will cover the *preventive care services* shown below when they are provided for a dependent *child* under 7 years of age: The *calendar year* deductible will not apply to these services. No copayment will apply to these services.

1. A *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. This includes human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *plan* as *preventive care services*.

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*. This is considered to be a *preventive care service*. The *calendar year* deductible will not apply to these services. No copayment will apply to these services.

Physical Exam (Members Age 7 and Over). We will pay for the following *preventive care services* when provided for an *member* age 7 or over. The *calendar year* deductible will not apply to these services. No copayment will apply to these services.

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".
4. Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *plan* as *preventive care services*.

Prostate cancer screenings, cervical cancer screenings including human papillomavirus (HPV) screening, breast cancer screenings, colorectal cancer screenings, and other generally medically accepted cancer screenings performed in the absence of a diagnosed illness, injury, or health condition are not covered under this "Physical Exam" benefit but are covered under the "Adult Preventive Services" benefit, subject to the terms and conditions of this *plan* that apply to that benefit.

Adult Preventive Services. Services and supplies provided in connection with all generally medically accepted cancer screening tests including FDA-approved cancer screenings for cervical cancer and human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer, prostate cancer screenings, colorectal cancer screenings, and the office visit related to those services. Also included is human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. The Calendar Year Deductible will not apply to these services. Adult Preventive Services are considered to be *preventive care services*. No copayment will apply to these services.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially with Adult Preventive Services benefit (see "Adult Preventive Services").
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Allergy. Allergy testing and treatment, including serum.

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 of 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 costs 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

Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a *physician* under a treatment plan, including but not limited to:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury include 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 unless such care is determined to be *medically necessary*.

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, illness or other medical condition as *medically necessary*.

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, electro-acupuncture, 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 the *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.

Covered charges under 2 and 3 above for hearing aids are limited to one (1) hearing aid per ear, 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 and Orthotic 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. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
 - e. Alcohol swabs (no deductible, no copayment is required).
 - f. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

Items a through e above are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment"). Item f above is covered under your *plan's* benefits for prosthetic devices (see "Prosthetic and Orthotic Devices").

2. Diabetes education program which:
 - a. Is designed to teach a *member* 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 *member* 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 UTILIZATION REVIEW PROGRAM for details.

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 for a covered *member* when provided under the Food and Drug Administration (FDA) approved treatment regimen.

Pediatric Asthma Equipment and Supplies. The following items and services when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

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" provision 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.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs 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.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "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, as long as any injuries are not a result of a medical condition or an act of domestic violence; 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 unless, in the case of physical therapy, the person has been authorized for such therapy in a *hospital* setting (see UTILIZATION REVIEW PROGRAM). *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 implants, 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 "Reconstructive Surgery", "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. Any educational treatment or nutritional counseling, or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us. Such services are provided under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Excess Amounts. Any amounts in excess of *covered expense*.

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 REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.

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.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Government Treatment. Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, 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.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

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 the "Well Baby and Well Child Care," "Physical Exam (Members Age 7 and Over)" 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 unless the person has been authorized for such test in a *hospital* setting (see UTILIZATION REVIEW PROGRAM).

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.

Medicare Non-Compliance. Services and supplies not covered by Medicare due to non-compliance with Medicare requirements.

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 Anthem Blue Cross Life and Health under this *plan*. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by the *group*. However, the copays paid to UBH do go toward the satisfaction of the out-of-pocket maximum under this *plan*.

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

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by us.

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 when provided under the "Well Baby and Well Child Care," or "Physical Exam (Members Age 7 and Over)" 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, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL CARE THAT IS COVERED.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic and Orthotic Devices" 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 drugs or medicines. Cosmetics, health or beauty aids.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency* or *hospice* as specifically stated in the "Home Health Care", "Hospice Care", 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", or "Physical Therapy, Physical Medicine and Occupational Therapy" provision 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. Services of a private duty nurse except as specifically stated under the "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", "Physical Exam", "Adult Preventive Services", "Breast Cancer" or "Screening For Blood Lead Levels" 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.

Sex Transformation. Any procedures to change characteristics of the body to those of the opposite sex except as stated under the TRANSGENDER SURGERY BENEFITS.

Sterilization Reversal. Reversal of sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the *plan* in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine. This exclusion does not apply to telemedicine services specified as covered under the Telemedicine Program provision of MEDICAL CARE THAT IS COVERED.

Transportation and Travel Expense. Expense incurred for transportation, except as specifically stated in the "Ambulance" and "Transplant Travel Expense" provisions of MEDICAL CARE THAT IS COVERED and under the section called TRANSGENDER SURGERY BENEFITS. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance 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.

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.

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 UTILIZATION REVIEW 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 UTILIZATION REVIEW PROGRAM for details).

*The criteria and requirements are based on the guidelines stated in The World Professional Association for Transgender Health’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 Anthem Blue Cross Life and Health’s 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 DEDUCTIBLE

Each *year*, you will be responsible for satisfying the Calendar Year Deductible before the *plan* begins to pay benefits.

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 Anthem Blue Cross Life and Health, 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 UTILIZATION REVIEW 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 UTILIZATION REVIEW 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 UTILIZATION REVIEW 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 UTILIZATION REVIEW PROGRAM for details), this exclusion will not apply.

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 covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Benefit Reserve. A Benefit Reserve, if any, for a *calendar year* is created for a *member* under This Plan when a *member* is covered by more than one plan and This Plan is not the Principal Plan based on this Coordination of Benefits (COB) provision. The Benefit Reserve is the amount saved by the plan that is not the Principal Plan for the benefit of the *member*.

The following criteria are used to create a Benefit Reserve:

1. 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.
2. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered only under This Plan.
3. If This Plan is the Principal Plan, the benefits under This Plan will be determined without taking into account the benefits or services of any Other Plan. When This Plan is the Principal Plan, nothing will be applied to This Plan's Benefit Reserve.

Benefit Reserves for a *member* are not carried forward from one *year* to the next. At the end of each *calendar year*, the Benefit Reserve for a *member* returns to zero and a new Benefit Reserve is created for the next *calendar year*.

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 trustee 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

This provision will apply in determining a person's benefits under This Plan for any *calendar year* if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that *calendar year*.

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.

EFFECT OF THE BENEFIT RESERVE ON PLAN BENEFITS

The Benefit Reserve provisions will apply if This Plan is not the Principal Plan and the benefits under This Plan and any Other Plan exceed the Allowable Expense for the *calendar year*.

The Benefit Reserve is determined by subtracting the amount the Principal Plan paid from the amount This Plan would have paid had it been the Principal Plan.

When This Plan is not the Principal Plan, the amounts saved, determined on a claim-by-claim basis, are recorded as a benefit reserve and are used to pay Allowable Expenses, not otherwise paid, that are incurred by the *member* during the *calendar year*.

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 *member* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

For example: You are covered as a retired employee under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired employee would pay last.

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 our Customer Service unit at 1 (888) 209-7975 and give them your Medicare number. We will load it to our 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.

UTILIZATION REVIEW PROGRAM

Benefits are provided only for *medically necessary* and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

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: The Utilization Review Program 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*.

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.

This *plan* includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This *plan* requires that covered services be *medically necessary* for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. It is your responsibility to initiate the process and ask your *physician* to request pre-service review. You may also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines.

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".

UTILIZATION REVIEW REQUIREMENTS

The stages of utilization review are pre-service review, care coordination review and retrospective review.

Pre-service review determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the services listed below.

- Scheduled, non-emergency inpatient *hospital stays*.

Exceptions: Pre-service 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.
- Organ and tissue transplants.
- Transplant travel expense benefits.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Home infusion therapy.

- Splint therapy services or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull.
- Outpatient private duty nursing services.
- Transgender Surgery Benefit services.

Care Coordination review determines whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an *emergency* admission to the *hospital*.

Retrospective review is performed to review services that have already been provided. This applies in cases when pre-service or care coordination 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 stay*, the benefits to which you would have been otherwise entitled **will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.**

When pre-service review is not performed for the other services listed below, the benefits to which you would have been otherwise entitled **will be reduced by \$200 for each occurrence.**

2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Organ and tissue transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - Transplant travel expense benefits 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 transplant center approved by us; and
 - c. The transplant center is 250 miles or more from the recipient or donor's home.
 - Home health care services if:
 - a. The services can be safely provided in your home, as certified by your attending physician;
 - b. Your attending physician manages and directs your medical care at home; and
 - c. Your attending physician has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
 - Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending physician.
 - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
 - 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.

- Outpatient private duty nursing 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 licensed nurse (R.N., L.P.N. or L.V.N.).
- Transgender surgery services 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; and
 - ii. The transgender surgery must be performed at a specific facility designated by us which is approved for the transgender surgery requested.
- 3. Services for an *inpatient hospital stay* 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 provided 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. If the review is not performed your benefits will be reduced as shown in the "Effect on Benefits".

Pre-service Reviews

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.
2. 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.
3. We will certify services that are *medically necessary* and appropriate. For inpatient *hospital*, 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.

Care Coordination Reviews

1. If pre-service review was not performed, you or the provider of the service must contact us for care coordination 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. The toll-free number is printed on your identification card.
2. 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.

3. 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.

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 care coordination 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 care coordination review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification. If it is retroactively determined that benefits are not certifiable, the non-certification deductible will apply. (See SUMMARY OF BENEFITS.)

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 five business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

2. A decision on the medical necessity of a care coordination request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. 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.
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 to you and your *physician*.
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-service, care coordination 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 change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. For pre-service and care coordination requests, written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and care coordination reviews.
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 by telephone 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.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

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. Through a case manager, we have the right 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

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 by your health care professionals. 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 belongs to you and your *physician*. The *group* will not compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. 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.
2. Any 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*.
3. 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. 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

Utilization review 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 employee* 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 premiums or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medicaid, 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 *plan* terminates and is replaced by another group plan within 15 days.
2. You are not eligible if your coverage under this *plan* ends because premium is 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 consecutive month period of coverage requirement will be waived for *members* who have been covered under another UC plan then switch to this *plan* during an Open Enrollment and need 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.

The *claims administrator* will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

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 provided under this *plan* do not regulate the amounts charged by providers of medical 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 premiums are paid according to the terms of the *agreement*.

Medical Necessity. The benefits of this *plan* are provided only for services which are *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.

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 *members* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You, or someone on your behalf, must give us written notice of a claim within 20 days after you incur *covered expense* under this plan, or as soon as reasonably possible thereafter.

Claim Forms. After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending us written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

Proof of Loss. You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this *plan* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

Payment to Providers. We will pay the benefits of this *plan* directly to medical transportation providers. We will pay hospitals and other providers of service directly when *emergency* services and care are provided to you or one of your *family members*. We will continue such direct payment until the *emergency* care results in stabilization. Also, we will pay other providers of service directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, we will pay the benefits of this *plan* to that party. These payments will fulfill our obligation to you for those covered services.

Exception: Under certain circumstances we will pay the benefits of this *plan* directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide us the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;
2. If the *subscriber* does not reside with the patient, either a copy of the judicial order requiring the *employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;
3. If the *employee* does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the *employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order;
4. The name and address of the person to be reimbursed, the name and policy number of the *employee*, the name of the patient, and other necessary information related to the coverage.

Right of Recovery. Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

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.

Entire Contract. This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *agreement* which includes this certificate. The terms of the *agreement* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *agreement*.

Liability For Statements. No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *agreement*. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

Conformity with Laws. Any provision of the *policy* which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Physical Examination. At our expense, we have the right and opportunity to examine any *member* claiming benefits when and as often as reasonably necessary while a claim is pending.

Legal Actions. No attempt to recover on the plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

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 California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310. 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.
- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must be requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
 - a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
 - b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
 - c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 - d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
 - e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
 - f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
 - g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You are not required to go through our grievance process for more than 30 days. If your grievance needs expedited review, you are not required to go through our grievance process for more than three days.

You must request this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

Within three business days of receiving notice from the CDI 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*. Any newly developed or discovered relevant medical records identified by us or by a qualified *physician* 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 if your *physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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 California Department of Insurance ("CDI") 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 and an addressed envelope for you to use to request IMR 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 CDI will review your application for IMR to confirm that:

1. (a) Your provider has recommended a health care service as *medically necessary*, or
(b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
(c) You have been seen by a 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 need not participate in our grievance process for more than three days. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists 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 CDI 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 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.

BINDING ARBITRATION

THIS PROVISION DOES NOT APPLY TO CLASS ACTIONS

ALL DISPUTES INCLUDING, BUT NOT LIMITED TO, DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE *PLAN* OR ANY OTHER ISSUES RELATED TO THE *PLAN* AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health & Safety Code section 1363.1 requires specific disclosures in this regard including the following notice: "It is understood that any dispute as to medical malpractice, that is, 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 a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration." THE *MEMBER* AND ANTHEM BLUE CROSS LIFE AND HEALTH AGREE TO BE BOUND BY THIS BINDING ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE *PLAN* OR ANY OTHER ISSUES RELATED TO THE *PLAN* AND MEDICAL MALPRACTICE CLAIMS.

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

The arbitration is initiated by the *member* making written demand on Anthem Blue Cross Life and Health. 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 agreement of the *member* and Anthem Blue Cross Life and Health, or by order of the court, if the *member* and Anthem Blue Cross Life and Health cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

The meanings of key terms used in this certificate 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 your certificate, 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.

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) is the company which insures the benefits of the *plan*.

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 Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. 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. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan*).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

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 by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

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, medical or psychiatric 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. Medical emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or her unborn *child*. 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 or psychiatric *emergency* or active labor.

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

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. 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 considered 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 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.

Some mental or nervous disorders are: schizophrenia, manic-depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; adjustment reactions; reactions to stress; hyperkinetic syndromes; attention deficit disorders; learning disabilities; conduct disorder; oppositional disorder; mental retardation; autistic disease of childhood; anorexia nervosa and bulimia. Mental or nervous disorders include *severe mental disorders* as defined in this plan (see definition of “severe mental disorders”).

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

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A facility which provides diagnostic radiology services
- A blood bank
- A durable medical equipment outlet
- A clinical laboratory
- *A skilled nursing facility*
- *A home health agency*
- A licensed ambulance company
- *A hospice*
- *An ambulatory surgical center*
- *An urgent care center*

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

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 dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.)
 - A licensed midwife
 - A marriage and family therapist (M.F.T.)
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*
 - An audiologist*
 - An occupational therapist (O.T.R.)*
 - A respiratory care practitioner (R.C.P.)*
 - A nurse practitioner
 - A *psychiatric mental health nurse* (R.N.)*
 - 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.

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 *employee* affected by the change.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the customer service number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

<http://www.healthcare.gov/center/regulations/prevention.html>

<http://www.ahrq.gov/clinic/uspstfix.htm>

<http://www.cdc.gov/vaccines/recs/acip/>

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.

Retired employee is a former *full-time employee* who meets the eligibility requirements described in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

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 an 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.

Telemedicine is the diagnosis, consultation, treatment, transfer of medical data and medical education through the use of advanced electronic communication technologies such as interactive audio, video or other electronic media that facilitates access to health care services or medical specialty expertise. Standard telephone, facsimile or electronic mail transmissions, or any combination therein, in the absence of other integrated information or data adequate for rendering a diagnosis or treatment, do not constitute telemedicine services.

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

Totally disabled subscriber is an employee who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Urgent care center is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call us at the customer service number listed on your ID card or you can also search online using the "Provider Finder" function on our website at www.anthem.com/ca/uc. Please call the *urgent care center* directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to Anthem Blue Cross Life and Health Insurance Company.

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*.

FOR YOUR INFORMATION

WEB SITE

Information specific to your benefits and claims history are available by calling 1 (888) 209-7975, printed on your identification card. Anthem Blue Cross Life and Health Insurance Company is an affiliate of Anthem Blue Cross is an affiliate of Blue Cross of California. You may use Blue Cross of California's web site to access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card. Simply log on to www.anthem.com/ca/uc. Access of the "Member Services" segment of the website requires a PIN. If you do not have a Personal Identification Number (PIN), you can request one at this page and it will be sent to you within seven (7) business days.

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to *members* with limited English proficiency.

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you.

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

To requesting a written or oral translation, please contact customer service by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance.

For more information about the Language Assistance Program visit www.anthem.com/ca/uc.

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the customer service telephone number listed on your ID card.

STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the customer service telephone number listed on your ID card.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:

**Anthem Blue Cross Life and Health Insurance Company
Customer Service
PO BOX 4310
Woodland Hills, CA 91365-4310
818-234-2700**

If the problem is not resolved, you may also contact the California Department of Insurance at:

**California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP (4357) – In California
1-213-897-8921 – Out of California
1-800-482-4833 – Telecommunication Device for the Deaf
E-mail Inquiry: “Consumer Services” link at
www.insurance.ca.gov**

