Core Plan

Benefit Booklet

University of California

Group Number: 976302

Effective Date: January 1, 2015

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This booklet constitutes a summary of the health Plan.

The Plan Document is on file with your Employer and a copy will be furnished upon request.

This is a Preferred Provider Medical Plan. Be sure you understand the Benefits of this Plan before Services are received.

NOTICE

Please read this Benefit Booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage.

Capitalized words have specific definitions. These can be found in the section describing the term or in the Definitions section.

IMPORTANT

No Member has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Group Continuation Coverage provision in this booklet.

Benefits of this Plan are available only for Services and supplies furnished during the term the Plan is in effect and while the individual claiming Benefits is actually covered by this Plan.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the Plan or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

University of California is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

This is not an insured plan. Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Note: The following Summary of Benefits contains the Benefits and applicable Copayments of your Plan. The Summary of Benefits represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of provisions, Benefits and exclusions of the Plan.

Summary of Benefits

Note: See the end of this Summary of Benefits for important benefit footnotes.

Summary of Benefits — Core Plan

Member Calendar Year Deductible[1] (Medical and Outpatient Prescription Drug Plan Deductible)	Deductible Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Calendar Year Medical Deductible	$3,000 per Individual	

Member Maximum Calendar Year Out-of-Pocket Responsibility[2]	Member Maximum Calendar Year Out-of-Pocket Amount[2, 3]
	Services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers
Calendar Year Out-of-Pocket Maximum	$6,350 per Individual / $12,700 per Family

Member Maximum Lifetime Benefits	Maximum Claims Administrator Payment	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Lifetime Benefit Maximum	No maximum	

Reduced Payment(s)	
Reduced Payment(s) for Failure to Obtain Prior Authorization (applies to Services by Non-Participating Providers only)	
Failure to obtain Prior Authorization for each non-Emergency Hospital and Skilled Nursing Facility admission Refer to the Reduced Payment for Failure to Obtain Prior Authorization section for any reduced payments which may apply.	$250 per Hospital or Skilled Nursing Facility admission $250 per Hospital admission for the diagnosis or treatment of Substance Abuse Conditions

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Acupuncture Benefits (24 combined visits with Chiropractic Benefits per Member per Calendar Year maximum) If your Plan has a Calendar Year Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.		
Acupuncture services – office location	20%	20%
Allergy Testing and Treatment Benefits		
Allergy serum purchased separately for treatment	20%	20%
Office visits (includes visits for allergy serum injections)	20%	20%
Ambulance Benefits		
Emergency or authorized transport	20%[6]	20%[6]
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.		
Ambulatory surgery center Outpatient surgery facility Services	20%	20% of up to $350 per day
Ambulatory surgery center Outpatient surgery Physician Services	20%	20%
Bariatric Surgery Benefits All bariatric surgery Services must be prior authorized, in writing, from the Claims Administrator's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.	**Services by Preferred and Participating Providers**	**Services by Non-Preferred and Non-Participating Providers[5]**
Bariatric Surgery Benefits for residents of designated counties in California All bariatric surgery Services for residents of designated counties in California must be provided by a Preferred Bariatric Surgery Services Provider. Travel expenses may be covered under this Benefit for residents of designated counties in California. See the Bariatric Surgery Benefits section, the paragraphs under Bariatric Surgery Benefits for Residents of Designated Counties in California, in Principal Benefits and Coverages (Covered Services) for a description.		
Hospital Inpatient Services	20%	Not covered
Hospital Outpatient Services	20%	Not covered
Physician bariatric surgery Services	20%	Not covered
Bariatric Surgery Benefits for residents of non-designated counties in California		
Hospital Inpatient Services	20%	Not covered
Hospital Outpatient Services	20%	Not covered
Physician bariatric surgery Services	20%	Not covered

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Chiropractic Benefits (24 combined visits with Acupuncture Benefits per Member per Calendar Year maximum) If your Plan has a Calendar Year Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.		
Chiropractic Services – office location	20%	20%
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits		
Clinical trial for Treatment of Cancer or Life-Threatening Conditions Services for routine patient care, not including research costs, will be paid on the same basis and at the same Benefit levels as other Covered Services shown in this Summary of Benefits. The research costs may be covered by the clinical trial sponsor.	You pay nothing	You pay nothing
Diabetes Care Benefits		
Devices, equipment and supplies	20%	20%
Diabetes self-management training – office location -	20%	20%
Dialysis Center Benefits		
Dialysis Services Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) of this Summary of Benefits.	20%	20% of up to $300 per day
Durable Medical Equipment Benefits		
Breast pump	You pay nothing	20%
Other Durable Medical Equipment	20%	20%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Emergency Room Benefits		
Emergency room Physician Services Note: After Services have been provided, the Claims Administrator may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Preferred and Non-Preferred Provider levels as specified under Professional (Physician) Benefits, Outpatient Physician Services, other than an office setting in this Summary of Benefits. The Services will also be subject to any Calendar Year medical Deductible.	20%	20%
Emergency room Services not resulting in admission Note: After Services have been provided, the Claims Administrator may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Preferred and Non-Preferred Provider levels as specified under Hospital Benefits (Facility Services), Outpatient Services for treatment of illness, or injury, radiation therapy, chemotherapy and necessary supplies in this Summary of Benefits. The Services will also be subject to any Calendar Year medical Deductible.	20%	20%
Emergency room Services resulting in admission (Billed as part of Inpatient Hospital Services)	20%	20%[7]
Family Planning Benefits Note: Copayments listed in this section are for Outpatient Physician Services only. If Services are performed at a facility (Hospital, ambulatory surgery center, etc.), the facility Copayment listed under the appropriate facility Benefit in this Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), intrauterine device (IUD), and tubal ligation.		
Counseling and consulting (Including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives)	You pay nothing	20%
Diaphragm fitting procedure	You pay nothing	20%
Implantable contraceptives	You pay nothing	20%
Infertility Services - Diagnosis of cause of Infertility (treatment of Infertility and in-vitro fertilization and artificial insemination not covered)	20%	20%
Injectable contraceptives	You pay nothing	20%
Insertion and/or removal of intrauterine device (IUD)	You pay nothing	20%
Intrauterine device (IUD)	You pay nothing	20%
Tubal ligation	You pay nothing	20%
Vasectomy	20%	20%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Home Health Care Benefits		
Home health care agency Services (including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist) Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers If your Plan has a Calendar Year medical Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	20%	Not covered[8]
Medical supplies	20%	Not covered[8]
Home Infusion/Home Injectable Therapy Benefits		
Hemophilia home infusion Services provided by a hemophilia infusion provider and prior authorized by the Plan. Includes blood factor product.	20%	Not covered[8]
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit as described at the back of this booklet.	20%	Not covered[8]
Home visits by an infusion nurse Home infusion agency nursing visits are not subject to the Home Health Care Calendar Year visit limitation	20%	Not covered[8]
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program All Hospice Program Benefits must be prior authorized by the Plan and must be received from a Participating Hospice Agency.		
24-hour Continuous Home Care	20%	Not covered[9]
General Inpatient care	20%	Not covered[9]
Inpatient Respite Care	20%	Not covered[9]
Pre-hospice consultation	20%	Not covered[9]
Routine home care	20%	Not covered[9]

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Hospital Benefits (Facility Services)		
Inpatient Emergency Facility Services	20%	20%
Inpatient non-Emergency Facility Services Semi-private room and board, and Medically Necessary Services and supplies, including Subacute Care. For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section. Prior authorization required by the Plan. (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $600 Allowable Amount times (x) 20% Participant contribution = Participant payment of up to $120.	20%	20% of up to $600 per day
Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year medical Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	20%	20% of up to $600 per day
Inpatient Services to treat acute medical complications of detoxification	20%	20% of up to $600 per day
Outpatient diagnostic testing X-ray, diagnostic examination and clinical laboratory Services Note: These Benefits are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $350 Allowable Amount times (x) 20% Participant contribution=Participant payment of up to $70	20%	20% of up to $350 per day
Outpatient dialysis Services (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $300 Allowable Amount times (x) 20% Participant contribution=Participant payment of up to $60	20%	20% of up to $300 per day
Outpatient Services for surgery and necessary supplies (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $350 Allowable Amount times (x) 20% Participant contribution=Participant payment of up to $70	20%	20% of up to $350 per day
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $350 Allowable Amount times (x) 20% Participant contribution=Participant payment of up to $70	20%	20% of up to $350 per day

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity (Be sure to read the Principal Benefits and Coverages (Covered Services) section for a complete description.)		
Ambulatory Surgery Center Outpatient Surgery facility Services	20%	20% of up to $350 per day
Inpatient Hospital Services	20%	20% of up to $600 per day
Office location	20%	20%
Outpatient department of a Hospital	20%	20% of up to $350 per day
Mental Health and Substance Abuse Benefits[10, 11]	**Services by Participating Providers**	**Services by Non-Participating Providers[12]**
Inpatient Mental Health and Substance Abuse Services		
Inpatient Hospital Services	20%	20% of up to $600 per day[13]
Inpatient Professional (Physician) Services	20%	20%
Residential care for Mental Health Condition	20%	20% of up to $600 per day
Residential care for Substance Abuse Condition	20%	20% of up to $600 per day
Non-Routine Outpatient Mental Health and Substance Abuse Services		
Electroconvulsive Therapy (ECT)[14]	20%	20%
Intensive Outpatient Program [14]	20%	20%
Office-based opioid treatment: outpatient opioid detoxification and/or maintenance therapy including methadone maintenance treatment	20%	20%
Partial Hospitalization Program[15]	20% per episode	20% per episode
Psychological testing to determine mental health diagnosis	20%	20%
Transcranial magnetic stimulation	20%	20%
Routine Outpatient Mental Health and Substance Abuse Services		
Professional (Physician) office visits	20%	20%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Orthotics Benefits		
Office visits	20%	20%
Orthotic equipment and devices	20%	20%
Outpatient Prescription Drug Benefits		
Outpatient Prescription Drug coverage is described separately at the back of this booklet.		
Outpatient X-ray, Pathology, and Laboratory Benefits Note: Benefits in this section are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. For Benefits for diagnostic radiological procedures such as CT scans, MRIs, MRAs, PET scans, etc. see the Radiological and Nuclear Imaging Benefits section of this Summary of Benefits. Outpatient diagnostic X-ray, pathology, diagnostic examination and clinical laboratory Services, including mammography and Papanicolaou test.		
Outpatient Laboratory Center or Outpatient Radiology Center Note: Preferred Laboratory Centers and Preferred Radiology Centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital. Laboratory and radiology Services obtained from a Hospital or Hospital-affiliated laboratory and radiology center will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) of this Summary of Benefits.	20%[16]	20%[16]
PKU Related Formulas and Special Food Products Benefits		
PKU Related Formulas and Special Food Products	20%	20%
Podiatric Benefits		
Podiatric Services – office location	20%	20%
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Principal Benefits and Coverages (Covered Services) section. When covered, Services will pay as any other surgery as noted in this Summary of Benefits.		
All necessary Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	20%	20% of up to $600 per day
Prenatal and postnatal Physician office visits (including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy)	20%	20%
Abortion Services Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility coinsurance may apply.	20%	20%
Preventive Health Benefits		
Preventive Health Services See the description of Preventive Health Services in the Definitions section for more information.	You pay nothing	20%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Professional (Physician) Benefits [17]		
Inpatient Physician Services For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section	20%	20%
Outpatient Physician Services, other than an office setting	20%	20%
Physician home visits	20%	20%
Physician office visits Note: For other Services with the office visit, you may incur an additional Benefit Copayment as listed for that Service within this Summary of Benefits. This additional Benefit Copayment may be subject to the Plan's medical Deductible. Additionally, certain Physician office visits may have a Copayment amount that is different from the one stated here. For those Physician office visits, the Copayment will be as stated elsewhere in this Summary of Benefits.	20%	20%
Teladoc Teladoc provides access to U.S. board-certified doctors 24/7/365 via phone or online video consults for urgent, non-emergency medical assistance, including the ability to write prescriptions, when you are unable to see your primary care physician. This service is available by calling 1-800-Teladoc (835-2362).	20%	Not covered
Prosthetic Appliances Benefits		
Office visits	20%	20%
Prosthetic equipment and devices	20%	20%
Radiological and Nuclear Imaging Benefits Note: Benefits in this section are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. Outpatient non-emergency radiological and nuclear imaging procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine. Prior authorization required by the Plan.		
Outpatient department of a Hospital Prior authorization required by the Plan.	20%	20% of up to $350 per day[16]
Radiology Center Note: Preferred Radiology Centers may not be available in all areas. Prior authorization required by the Plan.	20%[16]	20%[16]

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits		
Office location	20%[4]	20%
Outpatient department of a Hospital	20%[4]	20% of up to $350 per day
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year medical Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	20%[4]	20%[4]
Speech Therapy Benefits Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.		
Office location	20%	20%
Outpatient department of a Hospital	20%[4]	20% of up to $350 per day
Transplant Benefits - Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin		
Hospital Services	20%	20% of up to $600 per day
Professional (Physician) Services	20%	20%
Transplant Benefits - Special Note: The Claims Administrator requires prior authorization from the Claims Administrator's Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by the Claims Administrator. Please see the Transplant Benefits - Special portion of the Principal Benefits (Covered Services) section in the Benefit Booklet for important information on this benefit. Authorized travel expenses may be covered under this Benefit. See the Transplant Benefits - Special portion of the Principal Benefits (Covered Services) for a description.		
Facility Services in a Special Transplant Facility	20%	Not covered
Professional (Physician) Services	20%	Not covered

Summary of Benefits

Footnotes

[1] Copayments or Coinsurance paid for Covered Services will accrue to a Member Calendar Year Deductible (Medical Plan Deductible) except for the following Covered Services:
- Breast pump as listed under Durable Medical Equipment Benefits;
- Contraceptive Drugs and Devices provided under Outpatient Prescription Drug Benefits;
- Covered travel expenses for Bariatric Surgery Services, and Transplant Benefits;
- Emergency room Facility Services not resulting in an admission;
- Family planning counseling and consultation Services, diaphragm fitting procedure, injectable contraceptives by a Physician, implantable contraceptives, insertion and/or removal of intrauterine device, intrauterine device, and tubal ligation by Preferred Providers;
- Preventive health Benefits by Preferred Providers;
- Smoking cessation Drugs with prescription provided under Outpatient Prescription Drug Benefits.

[2] Copayments or Coinsurance for Covered Services accrue to the Member maximum Calendar Year out-of-pocket responsibility, except Copayments for:
- Additional and reduced payments under the Benefits Management Program;
- Charges by Non-Preferred Providers in excess of covered amounts;
- Charges in excess of specified benefit maximums;
- Covered travel expenses for Bariatric Surgery Services, and Transplant Benefits;

Note: Copayments and charges for Services not accruing to the maximum Calendar Year out-of-pocket responsibility continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

[3] Copayments are calculated based on the Allowable Amount, unless otherwise specified.

[4] For Covered Services from Other Providers you are responsible for applicable Deductible Copayment or Coinsurance and any charges above the Allowable Amount.

[5] For Covered Services from Non-Preferred and Non-Participating Providers you are responsible for a Copayment or Coinsurance and all charges above the Allowable Amount.

[6] The Copayment or Coinsurance will be calculated based upon the provider's billed charges or the amount the provider has otherwise agreed to accept as payment in full from the Plan, whichever is less.

[7] If you receive emergency room Services that are determined to not be Emergency Services and which result in admission as an Inpatient to a Non-Preferred Hospital, you will be responsible for a Non-Preferred Hospital Inpatient Services Copayment.

[8] Services from a Non-Participating Home Health Agency or Non-Participating Home Infusion Agency are not covered unless prior authorized by the Plan. When Services are authorized, your Copayment will be calculated at the Participating Provider level based upon the agreed upon rate between the Plan and the agency.

[9] Services from a Non-Participating Hospice Agency are not covered unless prior authorized by the Plan. When Services are authorized, your Copayment will be calculated at the Participating Provider level based upon the agreed upon rate between the Plan and the agency.

[10] Inpatient Services to treat acute medical complications of detoxification are not considered the treatment of Substance Abuse Conditions and are covered under Hospital Benefits.

[11] Prior authorization is required for all non-Emergency Inpatient Services, and Non-Routine Outpatient Mental Health and Substance Abuse Services. No prior authorization is required for Routine Outpatient Mental Health and Substance Abuse Services – Professional (Physician) Office Visit.

[12] For Services by Non-Participating Providers you are responsible for a Copayment and all charges above the Allowable Amount.

[13] For Emergency Services received from a Non-Participating Hospital, your Copayment will be the Participating Provider level, based on the Allowable Amount.

[14] This Copayment includes both Outpatient facility and Professional (Physician) Services.

[15] For Non-Routine Outpatient Mental Health and Substance Abuse Services - Partial Hospitalization Program services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.

[16] A Copayment will apply for each provider and date of service.

[17] All Professional Physician Services rendered by a Non-Preferred Radiologist, Anesthesiologist, and Pathologist in a Preferred facility are paid at the Preferred level of Benefits.

Note:
For Benefits in the United States but outside of California:

All Covered Services provided through BlueCard Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/BlueShield provider. Covered Services received from a local Blue Cross Blue Shield contracted provider are paid at the preferred level when billed through the local Blue Plan. A 24 hour toll-free number is available when you are outside California or in the United States and need urgent Services. By calling (800) 810-2583 (BLUE), you will be informed about the nearest BlueCard participating provider.

For Benefits outside of the United States:

All Covered Services for emergency and non-emergency care will be eligible for reimbursement when received outside of the United States. Please refer to the Blue Shield Preferred tier for Covered Services and corresponding Member liability. Prescription Drugs are a benefit when obtained outside of the United States. You are responsible for obtaining an English language translation of the claim and all medical records. When you are out of the country, you can call either the toll-free BlueCard Access number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week, to locate the nearest BlueCard Worldwide Network provider.

INTRODUCTION

If you have questions about your Benefits, contact the Claims Administrator before Hospital or medical Services are received.

This Plan is designed to reduce the cost of health care to you, the Participant. In order to reduce your costs, much greater responsibility is placed on you.

You should read your Benefit Booklet carefully. Your booklet tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment and Deductible responsibilities.

When you need health care, present your Claims Administrator ID card to your Physician, Hospital, or other licensed healthcare provider. Your ID card has your Participant and group numbers on it. Be sure to include these numbers on all claims you submit to the Claims Administrator.

In order to receive the highest level of Benefits, you should assure that your provider is a Preferred Provider (see the "Preferred Providers" section).

You are responsible for following the provisions shown in the "Benefits Management Program" section of this booklet, including:

1. You or your Physician must obtain the Claims Administrator approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency Inpatient Hospital or Skilled Nursing Facility Services. (See the "Preferred Providers" section for information.)
2. You or your Physician must notify the Claims Administrator within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Prior Authorization" in the "Benefits Management Program" section for a listing of Services requiring prior authorization.

Failure to meet these responsibilities may result in your incurring a substantial financial liability. Some Services may not be covered unless prior review and other requirements are met.

Note: The Claims Administrator will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Participant within 2 business days of the decision. For urgent Services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, the Claims Administrator will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

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

PREFERRED PROVIDERS

The Claims Administrator Preferred Plan is specifically designed for you to use the Claims Administrator Preferred Providers. Preferred Providers include certain Physicians, Hospitals, and Alternate Care Services Providers, and other Providers. Preferred Providers are listed in the Preferred Provider Directories. All Claims Administrator Physician Members are Preferred Providers. So are selected Hospitals in your community. Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and family therapists are also Preferred Providers. They are all listed in your Preferred Provider Directories.

To determine whether a provider is a Preferred Provider, consult the Preferred Provider Directory. You may also verify this information by accessing the Claims Administrator's Internet site located at http://www.blueshieldca.com/uc, or by calling Customer Service at the telephone number shown on the last page of this booklet. Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider Directory was published.

Note: In some instances Services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by the Claims Administrator for Services.

Preferred Providers agree to accept the Claims Administrator's payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability. This is not true of non-Preferred Providers.

You are not responsible to Participating and Preferred Providers for payment for Covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, and except as provided under the Exception for Other Coverage provision.

The Claims Administrator contracts with Hospitals and Physicians to provide Services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. If you want to know more about this payment system, contact Customer Service at the number provided on the back page of this booklet.

If you go to a Non-Preferred Provider, the Claims Administrator's payment for a Service by that Non-Preferred Provid-

er may be substantially less than the amount billed. You are responsible for the difference between the amount the Claims Administrator pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Payment for Emergency Services rendered by a Physician or Hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Claims Administrator within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

Directories of Preferred Providers located in your area are available online. If you need assistance finding a provider, please contact the Claims Administrator immediately and request them at the telephone number listed on the last page of this booklet.

CONTINUITY OF CARE BY A TERMINATED PROVIDER

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Claims Administrator provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES

If a Member is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for Services rendered under the Continuity of Care provisions shall be no greater than for the same Services rendered by a Preferred Provider in the same geographic area.

SUBMITTING A CLAIM FORM

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

You are paid directly by the Claims Administrator if Services are rendered by a Non-Preferred Provider. Payments to you for Covered Services are in amounts identical to those made directly to providers. Requests for payment must be submitted to the Claims Administrator within 1 year after the month Services were provided. Special claim forms are not necessary, but each claim submission must contain your name, home address, Plan number, Participant's number, a copy of the provider's billing showing the Services rendered, dates of treatment and the patient's name. The Claims Administrator will notify you of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Claims Administrator Participant's Statement of Claim form to the Claims Administrator service center listed on the last page of this booklet.

Claim forms are available on the Claims Administrator's Internet site located at http://www.blueshieldca.com/uc or you may call Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Claims Administrator claim form.

Be sure to send in a claim for all Covered Services even if you have not yet met your Calendar Year Deductible. The Claims Administrator will keep track of the Deductible for you. The Claims Administrator uses an Explanation of Benefits to describe how your claim was processed and to inform you of your financial responsibility.

ELIGIBILITY AND ENROLLMENT

The University establishes its own Medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

ELIGIBILITY

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members". A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members". A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

ENROLLMENT

Employees

Information pertaining to enrollment can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members". A copy of this fact sheet is avail-

able in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

Retirees

Information pertaining to enrollment can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members". A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

SERVICES FOR EMERGENCY CARE

The Benefits of this Plan will be provided for Covered Services received anywhere in the world for the emergency care of an illness or injury.

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

Note: For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up Services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician's office.

UTILIZATION REVIEW

State law requires that health plans disclose to Participants and health plan providers the process used to authorize or deny health care Services under the Plan. The Claims Administrator has completed documentation of this process as required under Section 1363.5 of the California Health and Safety Code. The document describing the Claims Administrator's Utilization Management Program is available online at www.blueshieldca.com or Participants may call the Customer Service Department at the number provided on the back page of this booklet to request a copy..

SECOND MEDICAL OPINION POLICY

If you have a question about your diagnosis, or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all Plan Benefit limitations and exclusions.

HEALTH EDUCATION AND HEALTH PROMOTION SERVICES

Health education and health promotion Services provided by the Claims Administrator's Center for Health and Wellness offer a variety of wellness resources including, but not limited to: a Participant newsletter and a prenatal health education program.

RETAIL-BASED HEALTH CLINICS

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com/uc. See the Preferred Providers section for information on the advantages of choosing a Preferred Provider.

NURSEHELP 24/7 SM

If you are unsure about what care you need, you should contact your Physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week. You can call NurseHelp 24/7 for immediate answers to your health questions. Registered nurses are available 24 hours a day to answer any of your health questions, including concerns about:

1. Symptoms you are experiencing, including whether you need emergency care;
2. Minor illnesses and injuries;
3. Chronic conditions;
4. Medical tests and medications;
5. Preventive care.

If your Physician's office is closed, just call NurseHelp 24/7 at 1-877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) The telephone number is listed on your Member identification card.

The NurseHelp 24/7 program provides Members with confidential telephone support for information, consultations, and referrals for health issues, at no charge. Members may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

Members may call a registered nurse toll free via 1-877-304-0504, 24 hours a day, to receive confidential support and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics.

THE CLAIMS ADMINISTRATOR ONLINE

The Claims Administrator's Internet site is located at http://www.blueshieldca.com/uc. Members with Internet access and a Web browser may view and download healthcare information.

BENEFITS MANAGEMENT PROGRAM

The Benefits Management Program applies utilization management and case management principles to assist Participants and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this Plan.

The Benefits Management Program includes: prior authorization requirements for Inpatient admissions, selected Inpatient and Outpatient Services office administered injectable drugs, and home infusion administered drugs, as well as emergency admission notification, and Inpatient utilization management. The program also includes Participant services such as discharge planning, case management and palliative care Services.

The following sections outline the requirements of the Benefits Management Program.

PRIOR AUTHORIZATION

Prior authorization allows the Participant and provider to verify with the Claims Administrator that (1) the proposed services are a Benefit of the Participant's Plan; (2) the proposed Services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Participant and provider when Benefits are limited to Services rendered by Participating Providers (See the Summary of Benefits).

A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Participant and provider within two business days of the decision. For urgent Services when the routine decision making process might seriously jeopardize the life or health of a Participant or when the Participant is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Participant's condition, not to exceed 72 hours from receipt of the request.

If prior authorization is not obtained, and services provided to the Participant are determined not to be a Benefit of the Plan, coverage will be denied.

Prior Authorization for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Participant or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed within California on an Outpatient, nonemergency basis:

1) CT (Computerized Tomography) scan
2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) Diagnostic cardiac procedures utilizing nuclear medicine

For authorized Services from a Non-Participating Provider, the Participant will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained and the radiological or nuclear imaging services provided to the Participant are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior Authorization for Medical Services Included on the Prior Authorization List

The "Prior Authorization List" is a list of designated medical and surgical Services that require prior authorization. Participants are encouraged to work with their providers to obtain prior authorization. Participants and providers may call Customer Service at the number provided on the back page of this booklet to inquire about the need for prior authorization. Providers may also access the Prior Authorization List on the provider website.

Failure to obtain prior authorization for hemophilia home infusion products and Services, home infusion/home injectable therapy or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage.

To obtain prior authorization, the Participant or provider should call Customer Service at the number listed on the back page of this Evidence of Coverage and Disclosure Form.

For authorized Services from a Non-Participating Provider, the Participant will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

For certain medical services, Benefits are limited to Services rendered by a Participating Provider. If prior authorization was not obtained and the medical services provided to the Participant are determined not to be a Benefit of the Plan, were not medically necessary, or were not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all nonemergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care, Special Transplant and bariatric surgery. The Participant or provider should call Customer Service at least five business days prior to the admission. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When inpatient Hospital admission is authorized to a Non-Participating Hospital, the Participant will be responsible for applicable Deductible, Copayment and Coinsurance

amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained for an Inpatient Hospital admission and the services provided to the Participant are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior authorization is not required for an emergency Hospital admission; See the Emergency Admission Notification section for additional information.

Prior Authorization for Mental Health or Substance Abuse Hospital Admissions and Non-Routine Outpatient Services

Prior authorization is required for all nonemergency mental health Hospital admissions including acute Inpatient care and Residential Care. The provider should call the Claims Administrator at 1-877-263-9952 at least five business days prior to the admission. Non-Routine Outpatient Mental Health Services, including, but not limited to, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized.

If prior authorization was not obtained for an inpatient mental health or substance abuse Hospital admission or for any Non-Routine Outpatient Mental Health or Substance Abuse Services and the services provided to the Member are determined not to be a Benefit of the plan, or were not medically necessary, coverage will be denied.

For an authorized admission to a Non-Participating Hospital or authorized Non-Routine Outpatient Mental Health Services from a Non-Participating Provider, the Participant will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

Prior authorization is not required for an emergency mental health or substance abuse Hospital admission; See the Emergency Admission Notification section for additional information.

Emergency Admission Notification

When a Participant is admitted to the Hospital for Emergency Services, the Claims Administrator should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Most Inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an Inpatient Hospital stay may be extended or reduced as warranted by the Participant's condition. When a determination is made that the Participant no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Participant. If discharge does not occur within 24 hours of notification, the Participant is responsible for all Inpatient charges accrued beyond the 24 hour timeframe.

Maternity Admissions: the minimum length of the Inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Inpatient stay is adequate.

Mastectomy: The length of the Inpatient stay is determined post-operatively by the attending Physician in consultation with the Participant.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, the Claims Administrator will work with the Participant, the attending Physician and the Hospital discharge planner to determine the most appropriate and cost effective way to provide this care.

Case Management

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Participant access necessary Services and to make the most efficient use of Plan Benefits. The Participant's nurse case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate Alternative care benefits are only utilized by mutual consent of the Participants, the provider, and the Claims Administrative and will not exceed the standard Benefits available under this Plan.

The approval of alternative benefits is specific to each Participant for a specified period of time. Such approval should not be construed as a waiver of The Claims Administrator's right to thereafter administer this Plan in strict accordance with its express terms. The Claim Administrator is not obligated to provide the same or similar alternative care benefits to any other Participant in any other instance.

Palliative Care Services

In conjunction with Covered Services, the Claim Administrator provides palliative care Services for Participants with serious illnesses. Palliative care Services include access to Physicians and nurse case managers who are trained to assist Participants in managing symptoms, in maximizing comfort, safety, autonomy and well-being, and in navigating a course of care. Participants can obtain assistance in making informed decisions about therapy, as well as documenting their quality of life choices. Participants may call the Customer Service Department to request more information about these services.

Reduced Payments for Failure to Obtain Prior Authorization (Applies to Services by Non-Participating Providers only)

For non-Emergency Services, payments may be reduced, as described below, when a Participant or Dependent fails to follow the procedures described under the Prior Authorization and Skilled Nursing Facility Admissions sections of the Benefits Management Program. Any applicable Calendar Year Deductible, Copayment and amounts in excess of Benefit dollar maximums specified will not be included in the calculation of the Participant's maximum Calendar Year Copayment responsibility.

1. Failure to contact the Claims Administrator as described under the Prior Authorization of the Benefits Management Program or failure to follow the recommendations of the Claims Administrator may result in reduction of payment per Hospital or Skilled Nursing Facility admission as described below, or non-payment by the Claims Administrator if it is determined that the admission is not a Covered Service.

    - *$250 per Hospital or Skilled Nursing Facility admission.
    - *$250 per Hospital admission for the diagnosis or treatment of Substance Abuse Conditions. Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Benefits and are not considered to be treatment of the Substance Abuse Condition itself.

Only one $250 reduced payment will apply to each Hospital admission for failure to follow the Benefits Management Program notification requirements or recommendations.

2. Failure to receive prior authorization for the radiological procedures listed in the Benefits Management Program section under Prior Authorization for Radiological and Nuclear Imaging Procedures or to follow the recommendations of the Claims Administrator will result in non-payment for procedures which are determined not to be Covered Services.

Deductible

For Zero Deductible Plans, there is no Calendar Year Deductible for Covered Services received from Preferred Providers, and the following Deductible and Services Not Subject to the Deductible sections only apply to Covered Services received from Non-Preferred Providers.

Calendar Year Deductible (Medical Plan Deductible)

The Calendar Year per Member and per Family Deductible amounts are shown on the Summary of Benefits. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for Covered Services without regard to any Deductible. This Deductible must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the Deductible. The Deductible must be satisfied once during each Calendar Year by or on behalf of each Member separately, except that the Deductible shall be deemed satisfied with respect to the Participant and all of his or her covered Dependents collectively after the Family Deductible amount has been satisfied. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan.

Services Not Subject to the Deductible

The Calendar Year Deductible applies to all Covered Services Incurred during a Calendar Year except for certain Services as listed in the Summary of Benefits.

No Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by the Plan for Covered Services provided under the Plan.

No Annual Dollar Limit on Essential Benefits

This Plan contains no annual dollar limits on essential benefits as defined by federal law.

Payment

The Member Copayment amounts, applicable Deductibles, and Copayment maximum amounts for Covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on Benefit and Copayment maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Out-of-Area Programs

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Claims Administrator calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. When Covered Services are received in another state, the Participant's Copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this booklet.

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Claims Administrator's payment practices in both instances are described in this booklet.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Claims Administrator for payment. The Claims Administrator will notify you of its determination within 30 days after receipt of the claim. The Claims Administrator will pay you at the Non-Preferred Provider Benefit level. Remember, your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by the Claims Administrator and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in Copayment calculations.

To receive the maximum Benefits of your Plan, please follow the procedure below.

When you require Covered Services while traveling outside of California:

1. call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at http://www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
2. visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable Copayment and Plan Deductible at the time you receive the Service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and Plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from the Claims Administrator, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.

Care for Services Outside the United States

Benefits will also be provided for covered emergency and non-emergency Services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need medical care while out of the country, call the BlueCard Worldwide Service Center either at the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, 7 days a week. In an emergency, go directly to the nearest Hospital. If your coverage requires precertification or prior authorization, you should also call the Claims Administrator at the customer service number noted on the back of your identification card. For Inpatient Hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a Physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at http://www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in this booklet). However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment and Deductible amounts, if any, as stated in this booklet.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this booklet.

Participant's Maximum Calendar Year Out-of-pocket Responsibility

The per Member and per Family maximum out-of-pocket responsibility each Calendar Year for Covered Services rendered by any combination of Preferred Providers, Non-Preferred Providers and Other Providers is shown on the Summary of Benefits.

Once a Member's maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for that Member's Covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for the Participant's and all covered Dependents' Covered Services for the remainder of that Calendar Year, except as described below.

Charges for Services which are not covered, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, and reduced payments Incurred under the Benefits Management Program are the Participant's responsibility and are not included in the maximum Calendar Year Copayment responsibility.

*Note: Certain Services and amounts are not included in the calculation of the maximum Calendar Year out-of-pocket responsibility. These items are shown on the Summary of Benefits.

Charges for these items may cause a Participant's payment responsibility to exceed the maximums.

Copayments and charges for Services not accruing to the Participant's maximum Calendar Year Copayment responsibility continue to be the Participant's responsibility after the Calendar Year Copayment maximum is reached.

Principal Benefits and Coverages (Covered Services)

Benefits are provided for the following Medically Necessary Covered Services, subject to applicable Deductibles, Copayments and charges in excess of Benefit maximums, Preferred Provider provisions and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Plan, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet. If there are two or more Medically Necessary Services that may be provided for the illness, injury or medical condition, the Claims Administrator will provide Benefits based on the most cost-effective service.

The Copayments for Covered Services, if applicable, are shown on the Summary of Benefits**.**

Note: Except as may be specifically indicated, for Services received from Non-Preferred and Non-Participating Providers Participants will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Participant Copayment.

Except as specifically provided herein, Services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Acupuncture Benefits

Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine (M.D.) licensed acupuncturist or other appropriately licensed or certified Health Care Provider up to a per Member per Calendar Year visit maximum as shown on the Summary of Benefits**.**

Allergy Testing and Treatment Benefits

Benefits are provided for allergy testing and treatment.

AMBULANCE BENEFITS

Benefits are provided for (1) emergency ambulance services (surface and air) when used to transport a Member from place of illness or injury to the closest medical facility where appropriate treatment can be received; or (2) pre-authorized, non-emergency ambulance transportation to or from one medical facility to another..

AMBULATORY SURGERY CENTER BENEFITS

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

Note: Reconstructive Surgery is only covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

BARIATRIC SURGERY BENEFITS FOR RESIDENTS OF DESIGNATED COUNTIES IN CALIFORNIA

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery Services must be prior authorized, in writing, from the Claims Administrator's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.

Services for Residents of Designated Counties in California

For Members who reside in a California county designated as having facilities contracting with the Claims Administrator to provide bariatric Services*, the Claims Administrator will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1. performed at a Preferred bariatric surgery Services Hospital or Ambulatory Surgery Center and by a Preferred bariatric surgery Services Physician that has contracted with the Claims Administrator to provide the procedure; and,
2. they are consistent with the Claims Administrator's medical policy; and,
3. prior authorization is obtained, in writing, from the Claims Administrator's Medical Director.

*See the list of designated counties below.

The Claims Administrator reserves the right to review all requests for prior authorization for these bariatric Benefits and to make a decision regarding benefits based on a) the medical circumstances of each patient, and b) consistency between the treatment proposed and the Claims Administrator medical policy.

For Members who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Preferred bariatric surgery Services Hospital by a Preferred bariatric surgery Services Physician will result in denial of claims for this benefit.

Note: Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must be provided by a Preferred Bariatric Surgery Services Physician, whether performed in a Preferred Bariatric Surgery Services Hospital, a qualified Ambulatory Surgery Center, or the Preferred Bariatric Surgery Services Physician's office.

The following are designated counties in which the Claims Administrator has contracted with facilities and physicians to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expense Reimbursement for Residents of Designated Counties in California

Members who reside in designated counties and who have obtained written authorization from the Claims Administrator to receive bariatric Services at a Preferred bariatric surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Member's home must be 50 or more miles from the nearest Preferred bariatric surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by the Claims Administrator. Approved travel-related expenses will be reimbursed as follows:

1. travel to and from the Preferred bariatric surgery Services Hospital on an approved flight, train, or current IRS mileage for auto travel; and
2. hotel accommodations not to exceed $200 per day for one room double occupancy; and
3. meals not to exceed $75/day per person; and
4. up to 6 round trips per Benefit, and
5. $5,000 one time maximum amount per surgery for recipient and companion expenses in total.

Covered bariatric travel expenses are not subject to the Calendar Year Deductible and do not accrue to the Member's maximum Calendar Year out-of-pocket responsibility.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Note: Bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described in the Summary of Benefits when:

1. Services are consistent with the Claims Administrator's medical policy; and,
2. prior authorization is obtained, in writing, from the Claims Administrator's Medical Director.

For Members who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

CHIROPRACTIC BENEFITS

Benefits are provided for Chiropractic Services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination subsequent office visits, adjustments, conjunctive therapy, and X-ray Services up to the Benefit maximum.

Benefits are limited to a per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

Covered X-ray Services provided in conjunction with this Benefit have an additional Copayment as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

CLINICAL TRIAL FOR TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS BENEFITS

Benefits are provided for routine patient care for a Member who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition when prior authorized by the Claims Administrator, and:

1. the clinical trial has a therapeutic intent and a Participating Provider determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and
2. the Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits.

"Routine patient care" consists of those Services that would otherwise be covered by the Plan if those Services were not provided in connection with an approved clinical trial, but does not include:

1. The investigational item, device, or service, itself;
2. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
3. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
4. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
5. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
6. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.
7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer and other life-threatening condition, and is limited to a trial that is:

1. Federally funded and approved by one or more of the following:

   b) one of the National Institutes of Health;

   c) the Centers for Disease Control and Prevention;

   d) the Agency for Health Care Research and Quality;

   e) the Centers for Medicare & Medicaid Services;

   f) a cooperative group or center of any of the entities in a to d, above; or the federal Departments of Defense or Veterans Administration;

   g) qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

   h) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

   "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

DIABETES CARE BENEFITS

Diabetes Equipment

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item and when Medically Necessary, for the management and treatment of diabetes when Medically Necessary:

1. blood glucose monitors, including those designed to assist the visually impaired;
2. insulin pumps and all related necessary supplies;
3. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;
4. visual aids, excluding eyewear and/or video-assisting devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drug Benefit section if selected as an optional Benefit by your Employer.

Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Member to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Services will be covered when provided by a Physicians, registered dieticianregistered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

DIALYSIS CENTERS BENEFITS

Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

Included in this Benefit are Medically Necessary dialysis related laboratory tests, equipment, medications, supplies and dialysis self-management training for home dialysis.

DURABLE MEDICAL EQUIPMENT BENEFITS

Medically Necessary Durable Medical Equipment for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by the Claims Administrator. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.

Medically Necessary Durable Medical Equipment for Activities of Daily Living, including repairs, is covered as described in this section, except as noted below:

1. No benefits are provided for rental charges in excess of the purchase cost;
2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item*

*This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (Note: For benefits for asthma inhales and inhaler spacers, see the Outpatient Prescription Drug Benefit if selected as an optional Benefit by your Employer.);

3. Breast pump rental or purchase is only covered if obtained from a designated Participating Provider in accordance with the Claims Administrator medical policy. For further information call Customer Service or go to http://www.blueshieldca.com/uc.

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.

Note: See the Diabetes Care Benefits section for devices, equipment and supplies for the management and treatment of diabetes.

For Members in a Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency.

EMERGENCY ROOM BENEFITS

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital. For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician's office.

Emergency Services are Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

When a Member is admitted to the Hospital for Emergency Services, the Claims Administrator should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by the Claims Administrator to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Claims Administrator determines is not an emergency will be paid as part of the Inpatient Hospital Services. The Member Copayment for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown on the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Member is responsible for the Emergency Room Member Copayment plus the appropriate Admitting Hospital Services Member Copayment as shown on the Summary of Benefits.

FAMILY PLANNING BENEFITS

Benefits are provided for the following Family Planning Services without illness or injury being present.

For Family Planning Services, for Plans with a Calendar Year Deductible for Services by Preferred Providers, the Calendar Year Deductible only applies to male sterilizations.

Note: No benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fitting or injectable contraceptives;
2. Intrauterine devices (IUDs), including insertion and/or removal;
3. Implantable contraceptives;
4. Infertility Services. Infertility Services, except as excluded in the Principal Limitations, Exceptions, Exclusions and Reductions section, including professional, Hospital, ambulatory surgery center, and ancillary Services to diagnose the cause of Infertility. Any services related to infertility treatment and to the harvesting or stimulation of the human ovum (including medications, laboratory and radiology service) are not covered.
5. Injectable contraceptives when administered by a Physician;
6. Voluntary sterilization (tubal ligation and vasectomy) and ;
7. Diaphragm fitting procedure.

HOME HEALTH CARE BENEFITS

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by the Member's Physician, and included in a written treatment plan.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by the Claims Administrator.

Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Person per Calendar Year visit maximum as shown on the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2. or 3. above;
5. Medical social worker.

For the purpose of this Benefit, visits from home health aides of 4 hours or less shall be considered as one visit.

In conjunction with professional Services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan are covered to the extent the Benefits would have been provided had the Member remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or under the Outpatient Prescription Drug Benefit.

Skilled Nursing Services are defined as a level of care that includes Services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: See the Hospice Program Services section for information about when a Member is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.

Note: For information concerning diabetes self-management training, see the Diabetes Care Benefits section.

HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS

Benefits are provided for home infusion and intravenous (IV) injectable therapy, except for Services related to hemophilia which are described below. Services include home infusion agency skilled nursing visits, parenteral nutrition Services, enteral nutritional Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency. Services from Non-Participating Home Infusion Agencies, shift care and private duty nursing must be prior authorized by the Claims Administrator.

This Benefit does not include medications, drugs, insulin, insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Benefits, and Services related to hemophilia which are described below.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion Agencies must be prior authorized by the Claims Administrator.

Hemophilia home infusion products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All Services must be prior authorized by the Claims Administrator (see the Benefits Management Program section for specific prior authorization requirements), and must be provided by a Preferred Hemophilia Infusion Provider. (Note: Most Participating Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) To find a Preferred Hemophilia Infusion Provider, consult the Preferred Provider Directory. You may also verify this information by calling Customer Service at the telephone number shown on the last page of this booklet.

Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following evaluation by your Physician, a prescription for a blood factor product must be submitted to and approved by the Claims Administrator. Once prior authorized by the Claims Administrator, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the Emergency Room Benefits section.)

Included in this Benefit is the blood factor product for in-home infusion use by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for Services in infusion suites managed by a Preferred Hemophilia Infusion Provider, and Medically Necessary Services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other medical benefits described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

This Benefit does not include:

1. physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2. services from a hemophilia treatment center or any Non-Preferred Hemophilia Infusion Provider; or,
3. self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), Outpatient Prescription Drug Benefits if selected as an optional Benefit by your Employer, or as described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

HOSPICE PROGRAM BENEFITS

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Member requests admission to and is formally admitted to an approved Hospice Program. The Member must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from the Claims Administrator. (Note: Members with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Members can continue to receive Covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider. Note: Hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by the Claims Administrator.

All of the Services listed below must be received through the Participating Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Members do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services and homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services/Counseling Services with medical social Services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Member to the extent that these needs are not met by the Member's other providers.
7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Member is Terminally ill.

DEFINITIONS APPLICABLE TO HOSPICE PROGRAM

Bereavement Services - services available to the immediate surviving family members for a period of at least one year after the death of the Member. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Member.

Continuous Home Care - home care provided during a Period of Crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

Home Health Aide Services - services providing for the personal care of the Terminally Ill Member and the performance of related tasks in the Member's home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursu-

ant to Chapter 8 of Division 2 of the Health and Safety Code.

Homemaker Services - services that assist in the maintenance of a safe and healthy environment and services to enable the Member to carry out the treatment plan.

Hospice Service or Hospice Program - a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and their family.
3. Requires the interdisciplinary team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Member's death to assist the family to cope with social and emotional needs associated with the death.
6. Actively utilizes volunteers in the delivery of Hospice Services.
7. Provides Services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.
8. Is provided through a Participating Hospice.

Interdisciplinary Team - the hospice care team that includes, but is not limited to, the Member and his or her family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction - Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Member's Participating Provider, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

Period of Care - the time when the Participating Provider recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than one year. A Period of Care starts the day the Member begins to receive hospice care and ends when the 90 or 60- day period has ended.

Period of Crisis - a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care - a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of a Member and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of Services delivered.

Respite Care Services – short-term Inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member.

Skilled Nursing Services - nursing Services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Member's provider to the Member and his family that pertain to the palliative, supportive services required by the Member with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Participant or Dependent assessment, evaluation, and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Member and his family and are available on a 24-hour on-call basis.

Social Service/Counseling Services - those counseling and spiritual Services that assist the Member and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Terminal Disease or Terminal Illness - a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

Volunteer Services - Services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Member and his family during the remaining days of the Member's life and to the surviving family following the Member's death.

HOSPITAL BENEFITS (FACILITY SERVICES)

(Other than Mental Health and Substance Abuse Benefits, Hospice Program Benefits, Skilled Nursing Facility Benefits, Dialysis Center Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California which are described elsewhere under Covered Services)

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.
2. Use of operating room and specialized treatment rooms.
3. In conjunction with a covered delivery, routine nursery care for a newborn of the Participant, covered spouse or Domestic Partner.
4. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
6. Rehabilitation when furnished by the Hospital and approved in advance by the Claims Administrator under its Benefits Management Program.
7. Drugs and oxygen.
8. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.
9. X-ray examination and laboratory tests.
10. Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
11. Use of medical appliances and equipment.
12. Subacute Care.
13. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
14. Medically Necessary Inpatient detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room, or when Medically Necessary Inpatient detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.
2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.
3. Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
4. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
6. Outpatient routine newborn circumcisions.*

   *For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

Covered Physical Therapy and Speech Therapy Services provided in an Outpatient Hospital setting are described under the Rehabilitation (Physical, Occupational and Respiratory Therapy) Benefits and Speech Therapy Benefits sections.

Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits

Benefits are provided for Hospital and professional Services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues, only to the extent that they are provided for:

1. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an Accidental Injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Member as determined by the Plan;

   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.
3. Medically Necessary non-surgical treatment (e.g., splint and Physical Therapy) of temporomandibular joint syndrome (TMJ);
4. surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5. Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones); or
6. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity; or
7. dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

1. services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
2. orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair), including treatment to alleviate TMJ;
3. dental implants (endosteal, subperiosteal or transosteal);
4. any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
5. alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth;
6. fluoride treatments except when used with radiation therapy to the oral cavity.

See Principal Limitations, Exceptions, Exclusions and Reductions, General Exclusions for additional services that are not covered.

Mental Health and Substance Abuse Benefits

All Non-Emergency Inpatient Mental Health Services, including Residential Care, and Non-Routine Outpatient Mental Health Services are subject to the Benefits Management Program and must be prior authorized by the Claims Administrator. See the Benefits Management Program section for complete information. See the "Out-Of-Area Program: The BlueCard Program" section of this booklet for an explanation of how payment is made for out of state Services.

Routine Outpatient Mental Health Services

Benefits are provided for professional (Physician) office visits for the diagnosis and treatment of Mental Health Conditions in the individual, family or group setting.

Non-Routine Outpatient Mental Health Services

Benefits are provided for Outpatient Facility and professional Services for the diagnosis and treatment of Mental Health Conditions. These Services may also be provided in the office, home or other non-institutional setting. Non-Routine Outpatient Mental Health Services include, but may not be limited to, the following:

1. Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure; used in the treatment of severe mental health conditions.

2. Intensive Outpatient Program - an Outpatient mental health treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

3. Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment.

4. Partial Hospitalization Program – an Outpatient treatment program that may be freestanding or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from Inpatient care following acute stabilization.

5. Psychological Testing - testing to diagnose a Mental Health Condition.

6. Transcranial Magnetic Stimulation - a noninvasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Inpatient Services

Benefits are provided for Inpatient Hospital and professional Services in connection with acute hospitalization for the treatment of Mental Health Conditions.

Benefits are provided for Inpatient and professional Services in connection with a Residential Care admission for the treatment of Mental Health Conditions.

See Hospital Benefits (Facility Services), Inpatient Services for Treatment of Illness or Injury for information on Medically Necessary Inpatient substance abuse detoxification.

ORTHOTICS BENEFITS

Benefits are provided for orthotic appliances, including:

1. shoes only when permanently attached to such appliances;

2. special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;

3. Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;

4. Medically Necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;

5. initial fitting and replacement after the expected life of the orthosis is covered.

Benefits are provided for orthotic devices for maintaining normal Activities of Daily Living only. No benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet. No benefits are provided for backup or alternate items.

Note: See the Diabetes Care Benefits section for devices, equipment, and supplies for the management and treatment of diabetes.

OUTPATIENT X-RAY, PATHOLOGY AND LABORATORY BENEFITS

Benefits are provided for diagnostic X-ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Routine laboratory Services performed as part of a preventive health screening are covered under the Preventive Health Benefits section.

Benefits are provided for genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with the Claims Administrator medical policy. (Note: See the section on Pregnancy and Maternity Care Benefits for genetic testing for prenatal diagnosis of genetic disorders of the fetus).

See the section on Radiological and Nuclear Imaging Benefits and the Benefits Management Program section for radi-

ological procedures which require prior authorization by the Claims Administrator.

PKU Related Formulas and Special Food Products Benefits

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products that are Medically Necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. All Benefits must be prescribed and/or ordered by the appropriate health care professional.

Podiatric Benefits

Podiatric Services include office visits and other Covered Services for the diagnosis and treatment of the food, ankle and related structures. These services, including surgical procedures, are customarily provided by a licensed doctor of podiatric medicine. Covered lab and X-ray Services provided in conjunction with this Benefit are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity Services, which include prenatal care, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy, Outpatient maternity Services, involuntary complications of pregnancy, and Inpatient Hospital maternity care including labor, delivery and post-delivery care. Involuntary complications of pregnancy include puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia. Benefits are also provided for abortion services. (Note: See the section on Outpatient X-ray, Pathology and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for services after termination of coverage under this Plan unless the Member qualifies for an extension of Benefits as described elsewhere in this booklet.

For Outpatient routine newborn circumcisions, for the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

Note: The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

Preventive Health Benefits

Preventive Health Services, as defined, are covered.

Professional (Physician) Benefits

(Other than Preventive Health Benefit, Mental Health and Substance Abuse Benefits, Hospice Program Benefits, Dialysis Center Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California which are described elsewhere under Covered Services.)

Professional Services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab and X-ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found in the Online Physician Directory located at http://www.blueshieldca.com/uc.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;
2. Services of consultants, including those for second medical opinion consultations;
3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests.
4. Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.
5. Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room;
6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;
7. Surgical procedures. When multiple surgical procedures are performed during the same operation, benefits for the secondary procedure(s) will be determined based on the Claims Administrator Medical Policy. Information regarding the Claims Administrator's Medical Policy can be obtained by going to http://www.blueshieldca.com/uc or by calling the toll-

free Customer Service number on your Identification Card. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;

8. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;
10. Extra time spent when a Physician is detained to treat a Member in critical condition;
11. Necessary preoperative treatment;
12. Treatment of burns;
13. Outpatient routine newborn circumcisions.*

    *For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth;

14. Diagnostic audiometry examination.
15. Teladoc consultations. Teladoc consultation Services provide confidential consultations using a network of board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. by secure online video, 7 days a week. If your Personal Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/uc. The Teladoc Physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

    Before this service can be accessed, you must complete a Medical History Disclosure form (MHD). The MHD form can be completed online on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc. Teladoc consultation Services are not intended to replace services from your Personal Physician but are a supplemental service. You do not need to contact your Personal Physician before using Teladoc consultation Services.

    Teladoc physicians do not issue prescriptions for substances controlled by the Drug Enforcement Agency (DEA), non-therapeutic, and/or certain other drugs which may be harmful because of potential for abuse.

PROSTHETIC APPLIANCES BENEFITS

Medically Necessary Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance. See General Exclusions under the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices.

Benefits are provided for Medically Necessary Prostheses for Activities of Daily Living, including the following:

1. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;
2. Artificial limbs and eyes;
3. Supplies necessary for the operation of Prostheses;
4. Initial fitting and replacement after the expected life of the item;
5. Repairs, even if due to damage.

No benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided). No benefits are provided for backup or alternate items.

Benefits are provided for contact lenses, if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia following cataract surgery when no intraocular lens has been implanted. Note: These contact lenses will not be covered under your Plan if your Employer provides supplemental Benefits for vision care that cover contact lenses through a vision plan purchased through the Claims Administrator. There is no coordination of benefits

between the health Plan and the vision plan for these Benefits.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

Radiological and Nuclear Imaging Benefits

The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization under the Benefits Management Program.

See the Benefits Management Program section for complete information.

1. CT (Computerized Tomography) scans;
2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and
5. any cardiac diagnostic procedure utilizing Nuclear Medicine.

Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan and when rendered in the provider's office or Outpatient department of a Hospital. The Claims Administrator reserves the right to periodically review the provider's treatment plan and records for medically necessity. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitation Services rendered in the home.

Skilled Nursing Facility Benefits

(Other than Hospice Program Benefits which are described elsewhere under Covered Services.)

Benefits are provided for Medically Necessary Services provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility or Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Member per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

Speech Therapy Benefits

Benefits are provided for outpatient Speech Therapy Services when ordered by a Physician and provided by an appropriately licensed speech therapist or appropriately licensed or certified Health Care Provider pursuant to a written treatment plan for an appropriate time to: (1) correct or improve the speech abnormality, or (2) to evaluate the effectiveness of treatment.

Services are provided for the correction of, or clinically significant improvement of, speech abnormalities that are the likely result of a diagnosed and identifiable medical condition, illness, or injury to the nervous system or to the vocal, swallowing, or auditory organs.

Continued Outpatient Benefits will be provided as long as treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records will be reviewed periodically for medically necessity.

Except as specified above and as stated under the Home Health Care Benefits and the Hospice Program Benefits sections, no Outpatient benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See the Home Health Care Benefits and Hospice program Benefits sections for information on coverage for Speech Therapy Services rendered in the home. See the Inpatient Services for Treatment of Illness or Injury section for information on Inpatient Benefits.

Transplant Benefits – Cornea, Kidney or Skin

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants only to the extent that:

1. they are provided in connection with the transplant of a cornea, kidney, or skin; and
2. the recipient of such transplant is a Participant or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

Transplant Benefits - Special

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with the Claims Administrator to provide the procedure, or in the case of Members accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by the Claims Administrator, (2) prior authorization is obtained, in writing, from the Claims Administrator's Medical Director and (3) the recipient of the transplant is a Participant or Dependent. Benefits include

services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

The Claims Administrator reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding benefits based on (1) the medical circumstances of each Member, and (2) consistency between the treatment proposed and the Claims Administrator medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;
2. Human lung transplants;
3. Human heart and lung transplants in combination;
4. Human liver transplants;
5. Human kidney and pancreas transplants in combination;
6. Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
7. Pediatric human small bowel transplants;
8. Pediatric and adult human small bowel and liver transplants in combination.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank.

Benefits are also provided for necessary travel and lodging expenses to receive these services when pre-authorized by the Plan.

Reimbursement for covered prior authorized travel expenses is limited to:

1. travel to and from the transplant center on an approved flight, train, or current IRS mileage for auto travel; and
2. hotel accommodations not to exceed $200 per day for one room double occupancy; and
3. meals not to exceed $75/day per person; and
4. up to 6 round trips per transplant, and
5. $5,000 per transplant maximum amount for recipient and companion expenses in total.

Covered transplant travel expenses are not subject to the Calendar Year Deductible and do not accrue to the Participant's maximum Calendar Year out-of-pocket responsibility.

Submission of adequate documentation including receipts is required before reimbursement will be made.

PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS

GENERAL EXCLUSIONS AND LIMITATIONS

Unless exceptions to the following exclusions are specifically made elsewhere in this booklet, no benefits are provided for the following services or supplies which are:

1. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy) and Hospice Program Benefits sections;
3. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
4. performed in a Hospital by house officers, residents, interns and others in training;
5. performed by a Close Relative or by a person who ordinarily resides in the covered Member's home;
6. for any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition;
7. for any services relating to the diagnosis or treatment of any Substance Abuse Condition except as specifically provided under Mental Health and Substance Abuse Benefits;
8. for hearing aids, unless your Employer has purchased hearing aids coverage as an optional Benefit, in which case an accompanying supplement provides the Benefit description;
9. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;
10. for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
11. for routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure,

employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;

12. for or incident to acupuncture, except as may be provided under Acupuncture Benefits;

13. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;

14. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

15. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits

16. for sexual dysfunctions and sexual inadequacies;

17. for or incident to the treatment of Infertility or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except as specifically listed under Family Planning Benefits and for Medically Necessary treatment of medical complications;

18. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;

19. which are Experimental or Investigational in Nature, except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits;

20. for testing for intelligence or learning disabilities, or behavioral problems or social skills training/therapy;

21. hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;

22. for dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

23. for or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

24. incident to organ transplant, except as explicitly listed under Transplant Benefits;

25. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for Medically Necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by the Claims Administrator consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:

    - Lower eyelid blepharoplasty;
    - Spider veins;
    - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
    - Hair removal by electrolysis or other means; and
    - Reimplantation of breast implants originally provided for cosmetic augmentation; and
    - Voice modification surgery.

26. for Reconstructive Surgery and procedures where there is another more appropriate covered surgical procedure, or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

    - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body.
    - Surgery to reform or reshape skin or bone.
    - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body.
    - Hair transplantation.

- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;

27. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;
28. for which the Member is not legally obligated to pay, or for services for which no charge is made;
29. incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Claims Administrator provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the Claims Administrator for the treatment of such injury or disease;
30. in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
31. for prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefit and except as provided through a Participating Hospice Agency;
32. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;
33. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;
34. for non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces, and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
35. incident to bariatric surgery Services, except as specifically provided under Bariatric Surgery Benefits for Residents of Designated Counties in California;
36. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy Benefits under the Claims Administrator health plan;
37. for services provided by an individual or entity that is not appropriately licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
38. for massage therapy;
39. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Member is receiving Hospice Services and except as may be provided under the Outpatient Prescription Drug Benefit or Home Infusion/Home Injectable Therapy Benefits in the Covered Services section;
40. not specifically listed as a Benefit.

MEDICAL NECESSITY EXCLUSION

The Benefits of this Plan are intended only for Services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. The Claims Administrator reserves the right to review all claims to determine if a service or supply is Medically Necessary. The Claims Administrator may use the services of Doctor of Medicine consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims. The Claims Administrator may limit or exclude benefits for services which are not necessary.

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medicare

1. Your Claims Administrator group plan will provide benefits before Medicare in the following situations:
    a. When you are eligible for Medicare due to age, if the Participant is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
    b. When you are eligible for Medicare due to disability, if the Participant is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
    c. When you are eligible for Medicare solely due to end-stage renal disease during the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
2. Your Claims Administrator group plan will provide benefits after Medicare in the following situations:

a. When you are eligible for Medicare due to age, if the Participant is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).

b. When you are eligible for Medicare due to disability, if the Participant is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).

c. When you are eligible for Medicare solely due to end-stage renal disease after the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.

d. When you are retired and age 65 years or older.

When your Claims Administrator group plan provides benefits after Medicare, the combined benefits from Medicare and your Claims Administrator group plan may be lower but will not exceed the Medicare allowed amount. Your Claims Administrator group plan Deductible and Copayments will be waived.

When you are eligible for Medi-Cal

Medi-Cal always provides benefits last.

When you are a qualified veteran

If you are a qualified veteran your Claims Administrator group plan will pay the reasonable value or the Claims Administrator's Allowable Amount for Covered Services provided to you at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Claims Administrator group plan will pay the reasonable value or the Claims Administrator's Allowable Amount for Covered Services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Claims Administrator group plan will equal, but not exceed, what the Claims Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or the Claims Administrator's Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how the Claims Administrator coordinates your group plan benefits in the above situations.

EXCEPTION FOR OTHER COVERAGE

Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Plan.

CLAIMS REVIEW

The Claims Administrator reserves the right to review all claims to determine if any exclusions or other limitations apply. The Claims Administrator may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

REDUCTIONS – THIRD PARTY LIABILITY

If a Member's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable or paid under the Plan unless the Member agrees in writing, in a form satisfactory to the Plan, to do all of the following:

1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;

2. Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery (defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from the Member's own uninsured or underinsured motorist coverage;

3. Execute a lien in favor of the Plan for the full amount of Benefits paid by the Plan;

4. Ensure that any Recovery (see below) is kept separate from and not comingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the Plan;

5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan, in writing, within 10 days after any Recovery has been obtained;

6. Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If a Member fails to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the Plan, through deductions from future benefit payments to the Member or others enrolled through the Member in the Plan.

"Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the Member or on the

Member's behalf, and without regard to whether the Member has been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in the name of the Member, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on behalf of the Member, such as an attorney-client trust account.

The Member shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, the Member shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

The Member's acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys fees and costs incurred in connection with the claims against the third party.

If the Member receives Services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from the Member the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such Services when payment or reimbursement is received by the Member for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

COORDINATION OF BENEFITS

When a Member who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for Hospital or medical expenses, such Member will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are Incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

If the covered Member is also entitled to benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the benefits of this Plan.

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the Member as an Employee will provide its benefits before the plan covering the Member as a Dependent.

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the Dependent child of a Member whose date of birth (excluding year of birth), occurs earlier in a Calendar Year, will determine its benefits before a plan which covers the Dependent child of a Member whose date of birth (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph will not apply, and the rule set forth in the plan which does not have the provisions of this paragraph will determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. Regardless of (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of that parent will determine its benefits before any other plan which covers the child as a Dependent child.
3. If the above rules do not apply, the plan which has covered the Member for the longer period of time will determine its benefits first, provided that:
    a. a plan covering a Member as a laid-off or retired Employee, or as a Dependent of that Member will determine its benefits after any other plan covering that Member as an Employee, other than a laid-off or retired Employee, or such Dependent; and
    b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then paragraph (a.) above will not apply.

If this Plan is the primary carrier in the case of a covered Member, then this Plan will provide its Benefits without making any reduction because of benefits available from any other plan, except that Physician Members and other Participating Providers may collect any difference between their billed charges and this Plan's payment, from the secondary carrier(s).

If this Plan is the secondary carrier in the order of payments, and the Claims Administrator is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Member (1) assigns to the Claims Administrator the right to receive benefits from the other plan to the extent of the difference between the benefits which the Claims Administrator actually pays and the amount that the Claims Administrator would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with the Claims Administrator in obtaining payment of benefits from the other plan, and (3) allows the Claims Administrator to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, the Claims Administrator may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as Benefits paid under this Plan. The Claims Administrator shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by the Claims Administrator in excess of the maximum amount of payment necessary to satisfy these provisions, the Claims Administrator shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

The Claims Administrator may release to or obtain from any organization or person any information which the Claims Administrator considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming Benefits under this Plan shall furnish the Claims Administrator with such information as may be necessary to implement these provisions.

COB Savings. A COB Savings, 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 primary carrier based on this Coordination of Benefits (COB) provisions. The COB Savings is the amount saved by the Plan that is not the primary carrier for the benefit of the Member.

The following criteria are used to create a COB Savings:

1. If this Plan is not the primary carrier, 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 primary carrier, 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 primary carrier, nothing will be applied to this Plan's COB Savings.

COB Savings for a Member are not carried forward from one year to the next. At the end of each calendar year, the COB Savings for a Member returns to zero and a new COB Savings is created for the next calendar year.

Effects of the COB Savings on the Plan Benefits

The COB Savings provisions will apply if this Plan is not the primary carrier and the benefits under this Plan and any other plan exceed the allowable expense for the calendar year.

The COB Savings is determined by subtracting the amount the primary carrier paid from the amount this Plan would have paid had it been the primary carrier.

When this Plan is not the primary carrier, the amounts saved, determined on a claim-by-claim basis, are recorded as a COB Savings and are used to pay allowable expenses, not otherwise paid, that are incurred by the member during the calendar year.

TERMINATION OF BENEFITS

The University establishes its own termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this health Plan.

De-enrollment Due to Loss of Eligible Status, Leave of Absence, Layoff, Change in Employment Status or Retirement

Coverage for you or your Dependents terminates at 11:59 p.m. Pacific Time on the last day of the month in which you or your Dependents become ineligible. 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 Individual Conversion Plan, the benefits may not be the same as you had under this Plan.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If your Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), your payment of fees will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsi-

ble for notifying you of the availability and duration of family leaves.

Other De-enrollments

Coverage for you or your Dependents terminates on the (1) the date the contract between the University and Blue Shield is discontinued, or (2) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer.

The Claims Administrator may terminate your and your Dependent's coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or the Claims Administrator;
2. Permitting use of your Participant identification card by someone other than yourself or your Dependents to obtain Services; or
3. Obtaining or attempting to obtain Services under the Plan by means of false, materially misleading, or fraudulent information, acts or omissions.

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Plan terminates, the Claims Administrator will extend the Benefits of this Plan, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness, or injury causing such Total Disability until the first to occur of the following: (1) 12 months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; (3) the date on which the covered Member's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Member. The time the Member was covered under this Plan will apply toward the replacement plan's pre-existing condition exclusion.

No extension will be granted unless the Claims Administrator receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by the Claims Administrator.

Group Continuation Coverage

Continuation of Group Coverage

Please examine your options carefully before declining this coverage.

COBRA

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows employees or retirees and their enrolled family member who lose group coverage because of certain "qualifying events" to elect continuation coverage for 18, 29, or 36 months. Qualifying events are situations that would ordinarily cause an individual to lose group health coverage.

An eligible employee or retiree and his/her enrolled family member(s) is entitled to elect continuation coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. Any change in benefits under the plan will also apply to COBRA enrollees.

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months.

1. The covered employee's separation from employment for reasons other than gross misconduct.
2. Reduction in the covered employee's hours to less than the number of hours required for eligibility.

The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined by the Social Security Administration (SSA) to be disabled within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

Three "qualifying events" allow eligible employees or retirees and their enrolled family member(s) to elect the continuation coverage for up to 36 months.

1. The employee's or retiree's death.
2. Divorce, legal separation or annulment of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.
3. A dependent child's loss of eligibility.

Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption.

If elected, COBRA continuation coverage is effective the first day of the month following the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the maximum coverage period or until any of the following events occur:

1. The termination of all employer provided group health plans;

2. The required premium for the Member's coverage is not paid on a timely basis;
3. The Member becomes covered by another group health plan after electing COBRA without limitations as to pre-existing conditions;
4. The Member becomes eligible for Medicare benefits after electing COBRA;
5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.
6. The Member notifies the plan or COBRA administrator that he/she wishes to cancel overage.

You will receive notice from your Employer's COBRA Administrator of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced.

Contact your Employer or your Employer's COBRA Administrator directly if you need more information about your eligibility for COBRA group continuation coverage.

CONTINUATION OF GROUP COVERAGE FOR MEMBERS ON MILITARY LEAVE

Continuation of group coverage is available for Members on military leave if the Member's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for Medical Disability.

GENERAL PROVISIONS

LIABILITY OF PARTICIPANTS IN THE EVENT OF NON-PAYMENT BY THE CLAIMS ADMINISTRATOR

In accordance with the Claims Administrator's established policies, and by statute, every contract between the Claims Administrator and its Participating Providers and Preferred Providers stipulates that the Participant shall not be responsible to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Participant's Plan. Participating Providers and Preferred Providers have agreed to accept the Plan's payment as payment-in-full for Covered Services, except for the Deductibles, Copayments, amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Participant is responsible for all amounts the Claims Administrator does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Participant is responsible for any charges above the Benefit maximums.

INDEPENDENT CONTRACTORS

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person receiving or providing Services, including any Physician, Hospital, or other provider or their employees.

NON-ASSIGNABILITY

Coverage or any Benefits of this Plan may not be assigned without the written consent of the Claims Administrator. Possession of an ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Member must be a Participant who has been accepted by the Employer and enrolled by the Claims Administrator and who has maintained enrollment under the terms of this Plan.

Participating Providers and Preferred Providers are paid directly by the Claims Administrator. The Member or the provider of Service may not request that payment be made directly to any other party.

If the Member receives Services from a Non-Preferred Provider, payment will be made directly to the Participant, and the Participant is responsible for payment to the Non-Preferred Provider. The Member or the provider of Service may not request that the payment be made directly to the provider of Service.

PLAN INTERPRETATION

The Claims Administrator shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine exception to participate in the Plan eligibility to receive Benefits under this Plan. The Claims Administrator shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Plan. Claims to eligibility or enrollment requirements should be directed to:

University of California Human Resources
300 Lakeshore Drive
Oakland, CA 94612

Toll-Free Telephone:
(800) 888-8267

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

The Claims Administrator protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information

and individually identifiable information, such as your name, address, telephone number, or social security number. The Claims Administrator will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING THE CLAIMS ADMINISTRATOR'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

The Claims Administrator's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed on the back of this booklet, or by accessing the Claims Administrator's internet site located at http://www.blueshieldca.com/uc and printing a copy.

If you are concerned that the Claims Administrator may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:

Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

Access to Information

The Claims Administrator may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Plan. You agree that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. You agree to assist the Claims Administrator in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the Claims Administrator with information in your possession. Failure to assist the Claims Administrator in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by the Claims Administrator will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Right of Recovery

Whenever payment on a claim has been made in error, the Claims Administrator will have the right to recover such payment from the Participant or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. The Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Participant or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant's or Member's eligibility, or payments on fraudulent claims.

Customer Service

If you have a question about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact the Customer Service Department as noted on the last page of this booklet.

The hearing impaired may contact the Customer Service Department through the Claims Administrator's toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Note: The Claims Administrator has established a procedure for our Participants and Dependents to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The Claims Administrator shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other healthcare Services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number provided on the last page of this booklet.

Settlement of Disputes

Internal Appeals

Initial Internal Appeal

If a claim for Benefits has been denied in whole or in part by the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may request that the Claims Administrator give further consideration to the claim by contacting the Customer Service Department via telephone or in writing including any additional information that would affect the processing of the claim. The Claims Administrator will acknowledge receipt of an appeal

within 5 calendar days. Written requests for initial internal appeal may be submitted to the following address:

Blue Shield of California
Attn: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Appeals must be filed within 180 days after you receive notice of an adverse benefit decision. Appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator.

Final Internal Appeal

If you are dissatisfied with the initial internal appeal determination by the Claims Administrator, the determination may be appealed in writing to the Claims Administrator within 60 days after the date of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish the Claims Administrator to consider. The Claims Administrator shall notify you in writing of the results of its review and the specific basis therefore. In the event the Claims Administrator finds all or part of the appeal to be valid, the Claims Administrator, on behalf of the Employer, shall reimburse you for those expenses which the Claims Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator. Written requests for final internal appeals may be submitted to:

Blue Shield of California
Attn: Final Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Expedited Appeal (Initial and Final)

You have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including but not limited to severe pain or potential loss of life, limb or major bodily function. The Claims Administrator will evaluate your request and medical condition to determine if it qualifies for an expedited decision. If it qualifies, your request will be processed as soon as possible to accommodate your condition, not to exceed 72 hours. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may call or write as instructed under the Initial and Final Appeals sections outlined above. Specifically state that you want an expedited decision and that waiting for the standard processing might seriously jeopardize your health.

External Review

Standard External Review

If you are dissatisfied with the final internal appeal determination, and the determination involves medical judgment or a rescission of coverage, you, a designated representative, a provider or an attorney on your behalf may request an external review within four months after notice of the final internal appeal determination. Instructions for filing a request for external review will be outlined in the final internal appeal response letter.

Expedited External Review

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within four months from the adverse benefit decision without participating in the initial or final internal appeal process. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may fax a request to (916) 350-7585, or write to the following address. Specifically state that you want an expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

Blue Shield of California
Attn: Expedited External Review
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Other Resources to Help You

For questions about your appeal rights, or for assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Definitions

Plan Provider Definitions

Whenever any of the following terms are capitalized in this booklet, they will have the meaning stated below:

Alternate Care Services Providers — Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Doctor of Medicine — a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Health Care Provider – An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

Hospice or Hospice Agency — an entity which provides Hospice services to Terminally Ill persons and holds a license, currently in effect as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed

pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital —

1. a licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home or nursing home or home for the aged is not included.
2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code.

Non-Participating Home Health Care and Home Infusion Agency — an agency which has not contracted with the Claims Administrator and whose services are not covered unless prior authorized by the Claims Administrator.

Non-Participating/Non-Preferred Providers — any provider who has not contracted with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Deductible, Copayment or amounts in excess of specified Benefit maximums, as payment-in-full for Covered Services. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider.

Non-Preferred Bariatric Surgery Services Providers — any provider that has not contracted with the Claims Administrator to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery Services provider by the Claims Administrator. Non-Preferred bariatric surgery Services Providers may include the Claims Administrator Preferred/Participating Providers if the provider does not also have an agreement with the Claims Administrator to provide bariatric surgery Services.

Note: Bariatric surgery services are not covered for Members who reside in designated counties in California if the service is provided by a Non-Preferred Bariatric Surgery Services Provider. (See the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Covered Services for more information.)

Non-Preferred Hemophilia Infusion Provider — a provider that has not contracted with the Claims Administrator to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has not been designated as a contracted hemophilia infusion product provider by the Claims Administrator. Note: Non-Preferred Hemophilia Infusion Providers may include Participating Home Health Care and Home Infusion Agency Providers if that provider does not also have an agreement with the Claims Administrator to furnish blood factor replacement products and services.

Other Providers —

1. Appropriately licensed or certified Independent Practitioners —licensed vocational nurse; registered nurses; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician, certified nurse midwife; licensed midwife; occupational therapist; acupuncturists; registered respiratory therapist; enterostomal therapist; speech therapists or speech pathologists; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.
2. Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

Outpatient Facility — a licensed facility, not a Physician's office or Hospital, that provides medical and/or surgical services on an Outpatient basis.

Participating Ambulatory Surgery Center — an Outpatient surgery facility which:

1. is either licensed by the state of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,
2. provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and,
3. has contracted with the Claims Administrator to provide Services on an Outpatient basis.

Participating Home Health Care and Home Infusion Agency — an agency which has contracted with the Claims Administrator to furnish services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion agency by the Claims Administrator. (See Non-Participating Home Health Care and Home Infusion agency definition above.)

Participating Hospice or Participating Hospice Agency — an entity which: (1) provides Hospice services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification; and (2) has either contracted with Blue Shield of California or has received prior approval from Blue

Shield of California to provide Hospice service Benefits pursuant to the California Health and Safety Code Section 1368.2.

Participating Physician — a selected Physician or a Physician Member that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment-in-full for Covered Services, except as provided under the Payment and Participant Copayment provision in this booklet.

Participating Provider — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment in full for Covered Services.

Note: This definition does not apply to Hospice Program Services. For Participating Providers for Hospice Program Services, see the Participating Hospice or Participating Hospice Agency definitions above.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member — a Doctor of Medicine who has enrolled with the Claims Administrator as a Physician Member.

Preferred Bariatric Surgery Services Provider — a Preferred Hospital or a Physician Member that has contracted with the Claims Administrator to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by the Claims Administrator.

Preferred Dialysis Center — a dialysis services facility which has contracted with the Claims Administrator to provide dialysis Services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Free-Standing Laboratory Facility (Laboratory Center) — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with the Claims Administrator to provide laboratory services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Free-Standing Radiology Facility (Radiology Center) — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with the Claims Administrator to provide radiology services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hemophilia Infusion Provider — a provider that has contracted with the Claims Administrator to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has been designated as a contracted Hemophilia Infusion Provider by the Claims Administrator.

Preferred Hospital — a Hospital under contract to the Claims Administrator which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Claims Administrator.

Preferred Provider — a Physician Member, Preferred Hospital, Preferred Dialysis Center, or Participating Provider.

Skilled Nursing Facility — a facility with a valid license issued by the California Department of Health Services as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country.

ALL OTHER DEFINITIONS

Whenever any of the following terms are capitalized in this booklet, they will have the meaning stated below:

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent, external source.

Activities of Daily Living (ADL) — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care — care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Allowable Amount — the Claims Administrator Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Claims Administrator Allowance, unless otherwise specified for a particular service elsewhere in this booklet, is:

1. For a Participating Provider, the amount that the Provider and the Claims Administrator have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a Non-Participating/Non-Preferred Provider (excluding a Hospital/ Outpatient Facility) in California who provides non-Emergency Services, the amount the Claims Administrator would have allowed for a Participating Provider performing the same service in the same geographical area.
3. For a Non-Participating/Non-Preferred Provider (excluding a Hospital/ Outpatient Facility) who provides

Emergency Services, the Reasonable and Customary Charge.

4. For a Hospital/ Outpatient Facility that is a Non-Participating/Non-Preferred Provider in California who provides Emergency or non-Emergency Services, the amount negotiated by the Claims Administrator.

5. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or

6. For a Non-Participating Provider (i.e., that does not contract with the Claims Administrator or a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides non-Emergency Services, the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a non-participating provider performing the same services. If the local plan has no Non-Participating Provider allowance, the Claims Administrator will assign the Allowable Amount used for a Non-Participating/Non-Preferred Provider in California.

Benefits (Services) — those Services which a Member is entitled to receive pursuant to the Plan Document.

Calendar Year — a period beginning on January 1 of any year and terminating on January 1 of the following year.

Chronic Care — care (different from Acute Care) furnished to treat an illness, injury or condition, which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary.

Claims Administrator — the claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.

Close Relative — the spouse, Domestic Partner, children, brothers, sisters, or parents of a covered Member.

Copayment — the dollar amount or percentage of the Allowable Amount unless otherwise specified that a Member is required to pay for specific Covered Services after meeting any applicable Deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) — those Services which a Member is entitled to receive pursuant to the terms of the Plan Document.

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. Title XVIII of the Social Security Act, e.g., Medicare.

3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.

4. Any other publicly sponsored or funded program of medical care.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care and/or supervisory care by a Physician) or care furnished to a Member who is mentally or physically disabled, and

1. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or

2. when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible — the Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Dependent and Domestic Partner—

Please refer to the "Eligible Family Members" section of the "Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members". A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

Durable Medical Equipment — equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes items such as wheelchairs, Hospital beds, respirators, and other items that the Claims Administrator determines are Durable Medical Equipment.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

Employee — an individual who meets the eligibility requirements established by the Employer and accepted by the Claims Administrator.

Employer — is The Regents of the University of California and its affiliate, Hastings College of the Law.

Enrollment Date — the first day of coverage, or if there is a waiting period, the first day of the waiting period (typically, date of hire).

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Participant and all enrolled Dependents.

Incurred — a charge will be considered to be "Incurred" on the date the particular service or supply which gives rise to it is provided or obtained.

Infertility — the Member must actively be trying to conceive and has:

1. the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
4. failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a Physician (the initial six cycles are not a benefit of this Plan); or
5. three or more pregnancy losses.

Inpatient — an individual who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

Medical Necessity (Medically Necessary) —

The Benefits of this Plan are provided only for Services which are medically necessary.

1. Services which are medically necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Claims Administrator, are:
    a. consistent with the Claims Administrator medical policy;
    b. consistent with the symptoms or diagnosis;
    c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
    d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, the Claims Administrator will provide benefits based on the most cost-effective service.
3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services not medically necessary include hospitalization:
    a. for diagnostic studies that could have been provided on an Outpatient basis;
    b. for medical observation or evaluation;

c. for personal comfort;

d. in a pain management center to treat or cure chronic pain; and

e. for Inpatient Rehabilitation that can be provided on an Outpatient basis.

4. The Claims Administrator reserves the right to review all claims to determine whether services are medically necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member/Individual — either a Participant or Dependent.

Mental Health Condition — mental disorders listed in the most current edition of the "Diagnostic & Statistical Manual of Mental Disorders" (DSM).

Mental Health Services — Services provided to treat a Mental Health Condition.

Occupational Therapy — treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period — that period of time set forth in the Plan Document during which eligible Employees and their Dependents may transfer from another health benefit plan sponsored by the Employer to this Plan.

Orthosis (Orthotics) — an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable body parts.

Out-of-Pocket Maximum - the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.

Outpatient — an individual receiving services but not as an Inpatient.

Partial Hospitalization Program (Day Treatment) — an Outpatient treatment program that may be free-standing or Hospital-based and provides services at least 5 hours per day, 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

Participant — an employee who has been enrolled by the Claims Administrator as a Participant and who has maintained enrollment in accordance with this Plan.

Physical Therapy — treatment provided by a Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan — the Core Plan (Medical and Prescription Drug Benefit Plan) for eligible Employees of the Employer.

Plan Administrator — is The Regents of the University of California.

Plan Document — the document issued by the Plan that establishes the services that Participants and Dependents are entitled to receive from the Plan.

Plan Sponsor — is The Regents of the University of California.

Preventive Health Services — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically listed below:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. With respect to women, such additional preventive care and screenings not described in paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at http://www.blueshieldca.com/uc or by calling Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1. through 4. above, the new recommendation will be covered as a Preventive Health Service no later than 12 months following the issuance of the recommendation.

Note: Diagnostic audiometry examinations are covered under the Professional (Physician) Benefits.

Prosthesis (Prosthetics) — an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Reasonable and Customary Charge — in California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Claims Administrator to be the reasonable and customary value for the services rendered by a Non-Participating Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered; outside of California: The lower of (1) the provider's billed charge, or, (2) the amount, if any, established by the laws of the state to be paid for Emergency Services, if applicable.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible; dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.

Rehabilitation — Inpatient or Outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory.

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

Retiree — an individual who meets the eligibility requirements established by the Employer and accepted by the Claims Administrator.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:
   (a) 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 either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;
   (b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — includes medically necessary healthcare services and medically necessary supplies furnished incident to those services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Special Food Products — a food product which is both of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;
2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment, under the direction of a Physician and provided by a licensed speech pathologist or speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient's vocal or swallowing skills which have been impaired by diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Substance Abuse Condition — for the purposes of this Plan, means any disorders caused by or relating to the recurrent use of alcohol, drugs, and related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

Total Disability (or Totally Disabled) —

1. in the case of an Employee or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual rea-

sonably might be expected to engage, in view of the individual's station in life and physical and mental capacity;

2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

Outpatient Prescription Drug Benefits

Summary of Benefits

Outpatient prescription Drugs are subject to the Calendar Year Deductible and the Member Maximum Calendar Year out-of-pocket Responsibility as stated under the medical benefits at the beginning of this booklet.

Benefit	Member Copayment	
	UC Pharmacy and Participating Pharmacy	**Non-Participating Pharmacy[1]**
Retail Prescriptions (30-day supply)		
Contraceptive Drugs and Devices[2]	$0 per prescription	$0 per prescription
Formulary Generic Drugs	20% per prescription	20% per prescription
Formulary Brand Drugs[3]	20% per prescription	20% per prescription
Non-Formulary Brand Drugs[3]	20% per prescription	20% per prescription
Smoking Cessation Drugs		
Over-the-counter Drugs with prescription	$0 per prescription	20% per prescription
Prescription Drugs	$0 per prescription	20% per prescription
Diabetic testing supplies		
Lancets and alcohol swabs	$0 per prescription	20% per prescription
Needles and syringes	20% per prescription	20% per prescription
Formulary test strips	$0 per prescription	20% per prescription
Non-formulary test strips	20% per prescription	20% per prescription
Mail Service Prescriptions through the Blue Shield mail service program (90-day supply)		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Formulary Generic Drugs	20% per prescription	Not covered
Formulary Brand Drugs[3]	20% per prescription	Not covered
Non-Formulary Brand Drugs[3]	20% per prescription	Not covered
Specialty Pharmacies and Select UC Pharmacies[4] (up to 30-day supply)		
Specialty Drugs	20% per prescription	Not covered
Oral Anticancer Medications[5]	20% up to a maximum of $200 per prescription	Not covered
UC Maintenance Drug Program (up to 90 day supply, available at select UC Pharmacies and specified retail pharmacies)		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Formulary Generic Drugs	20% per prescription	Not covered
Formulary Brand Drugs	20% per prescription	Not covered
Non-Formulary Brand Drugs	20% per prescription	Not covered

[1] To obtain prescription Drugs at a Non-Participating Pharmacy, the Member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. Member Copayment not to exceed billed charges.

[2] There is no Copayment for contraceptive drugs and devices, however, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost for the Brand contraceptive Drug and its Generic Drug equivalent. If the Brand contraceptive drug is Medically Necessary, it may be covered without a Copayment with prior authorization. The difference in cost does not accrue to the Deductible or Out-of-Pocket Maximum.

[3] If the Member or Physician requests a Brand Drug when a Generic Drug equivalent is available, and the Deductible has been satisfied (when applicable), the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.

[4] The Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in Outpatient Prescription Drug Benefits. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated.

[5] Subject to the Deductible, and Coinsurance shall not exceed $200 for an individual prescription for up to a 30-day supply of a prescribed orally administered anticancer medication.

This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan’s prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Outpatient Prescription Drug Benefits

Outpatient prescription Drugs are subject to the Calendar Year Deductible and the Member Maximum Calendar Year out-of-pocket Responsibility.

Benefits are provided for Outpatient prescription Drugs, which meet all of the requirements specified in this section, are prescribed by a Physician, except as noted below, and are obtained from a licensed Pharmacy.

The Claims Administrator's Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bioequivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Claims Administrator Outpatient Prescription Drug Benefit. Non-Formulary Drugs may be covered subject to higher Copayments. Select Drugs and Drug dosages and most Specialty Drugs require prior authorization by the Claims Administrator for Medical Necessity, including appropriateness of therapy and efficacy of lower cost alternatives. You and your Physician may request prior authorization from the Claims Administrator.

Coverage for selected Drugs may be limited to a specific quantity as described in "Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill".

Outpatient Drug Formulary

Medications are selected for inclusion in the Claims Administrator's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by the Claims Administrator's Pharmacy and Therapeutics Committee during scheduled meetings four times a year. The Formulary includes most Generic Drugs. The fact that a Drug is listed on the Claims Administrator Formulary does not guarantee that a Member's Physician will prescribe it for a particular medical condition.

Benefits may be provided for Non-Formulary Drugs subject to higher Copayments.

Members may call Member Services at the number listed on their Identification Card to inquire if a specific drug is included in the Formulary. Member Services can also provide Members with a printed copy of the Formulary. Members may also access the Formulary through the Claims Administrator web site at http://www.blueshieldca.com/uc.

Definitions

Anticancer Medications — Drugs used to kill or slow the growth of cancerous cells.

Brand Drugs — Drugs which are FDA approved either (1) after a new drug application, or (2) after an abbreviated new drug application and which has the same brand name as that of the manufacturer with the original FDA approval.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, test tablets and alcohol swabs), (5) over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B, (6) contraceptive Drugs and devices, including female OTC contraceptives drugs and devices, diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives and emergency contraceptives, when ordered by a Physician, and (7) inhalers and inhaler spacers for the management and treatment of asthma.

Note: To be considered for coverage, all Drugs require a valid prescription by the Member's Physician.

Formulary — a comprehensive list of Drugs maintained by the Claims Administrator's Pharmacy and Therapeutics Committee for use under the Claims Administrator Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent or authorized generic to the Brand Drug, (2) contain the same active ingredient as the Brand Drug, and (3) typically cost less than the Brand Drug equivalent.

Network Specialty Pharmacy – select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Specialty Drugs. Specialty Drugs may also be available at select UC medical center pharmacies.

To select a Specialty Pharmacy, you may go to http://www.blueshieldca.com/uc or call the toll-free Member Services number on your Blue Shield Identification Card.

Non-Formulary Drugs — Drugs determined by the Claims Administrator's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary drug alternatives. Benefits are provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

Non-Participating Pharmacy — a pharmacy which does not participate in the Claims Administrator Pharmacy Network.

Participating Pharmacy — a pharmacy which participates in the Claims Administrator Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for the Claims Administrator Members. Note: The Mail Service Pharmacy is a Participating Pharmacy.

To select a Participating Pharmacy, you may go to http://www.blueshieldca.com/uc or call the toll-free Customer Service number on your Identification Card.

Specialty Drugs — Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancer, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Claims Administrator's Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by the Claims Administrator's Pharmacy and Therapeutics Committee, be obtained from a the Claims Administrator Specialty Pharmacy and may require prior authorization for Medical Necessity by the Claims Administrator.

University of California (UC) Maintenance Drug Program

Members may obtain prescribed maintenance medications for up to a 3-month supply through Blue Shield's Mail Service Prescription Drug Program, select UC medical center pharmacies, or specified retail pharmacies. Location of available UC or specified retail pharmacies can be obtained by going to http://www.blueshieldca/uc.com or by calling the toll-free Customer Service number on your Blue Shield Identification Card.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain Drugs at a Participating Pharmacy, the Member must present his Identification Card. Note: Except for covered emergencies, claims for Drugs obtained without using the Identification Card will be denied.

Benefits are provided for Specialty Drugs only when obtained from a Network Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Specialty Drugs that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary from a Non-Participating Pharmacy.

Once the Calendar Year Deductible has been satisfied, the Member is responsible for paying the applicable Copayment for each prescription Drug at the time the Drug is obtained.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed and the Deductible is not applicable. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to the Claims Administrator for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy contracted rate.

You are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Claims Administrator Participating Pharmacy at the time the Drug is obtained, until the Deductible is satisfied (not applicable to contraceptive Drugs and devices).

If the Member or Physician requests a Brand Drug when a Generic Drug equivalent is available, the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the Member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

The Member or prescribing provider may provide information supporting the Medical Necessity for using a Brand Drug versus an available Generic Drug equivalent through the Blue Shield prior authorization process. See the section on *Prior Authorization Process* for information on the approval process. If the request is approved, the Member is responsible for paying the applicable Drug tier Co-payment or Coinsurance.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

To obtain prescription Drugs at a Non-Participating Pharmacy, the Member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. After the Calendar Year Deductible amount has been satisfied, the Member will be reimbursed as shown on the Summary of Benefits based on the price actually paid for the Drugs. Claims must be received within 1 year from the date of service to be considered for payment.

When Drugs are obtained at a Non-Participating Pharmacy for a covered emergency, the Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Pharmacy Services -Emergency Claims, P. O. Box 7168, San Francisco, CA 94120. The Member will be reimbursed the purchase price of covered prescription Drug(s) and any applicable Copayment(s). Claim forms may be obtained from the Claims Administrator Service Center. Claims must be received within 1 year from the date of service to be considered for payment.

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

When Drugs have been prescribed for a chronic condition, a Member he may obtain the Drug through the Claims Administrator's Mail Service Prescription Drug Program by enrolling online or by phone or mail. Members should allow up to 14 days to receive the Drugs. The Member's Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Specialty Drugs, are not available through the Mail Service Prescription Drug Program.

Once the Calendar Year Deductible has been satisfied, the Member is responsible for the applicable Mail Service Prescription Drug Copayment for each prescription Drug.

For more information about the Mail Service Prescription Drug Program or to determine applicable cost share, Members may visit www.blueshieldca.com/uc or call the toll-free Customer Service number on your Identification Card.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed and the Deductible is not applicable. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to the Claims Administrator for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy's contracted rate.

You are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Brand Drug to the Mail Service Pharmacy prior to your prescription being sent to you until the Deductible is satisfied (not applicable to contraceptive Drugs and devices).

If the Member or Physician requests a Mail Service Brand Drug when a Mail Service Generic Drug is available, the Member is responsible for the difference between the contracted rate for the Mail Service Brand Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment. This difference in cost that the Member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

The Member or prescribing provider may provide information supporting the Medical Necessity for using a Brand Drug versus an available Generic Drug equivalent through the Blue Shield prior authorization process. See the section on *Prior Authorization Process* for information on the approval process. If the request is approved, the Member is responsible for paying the applicable Drug tier Co-payment or Coinsurance.

Prior Authorization Process for Select Formulary, Non-Formulary and Specialty Drugs

Select Formulary Drugs, as well as most Specialty Drugs may require prior authorization for Medical Necessity. Select contraceptives may require prior authorization for Medical Necessity in order to be covered without a Copayment. Compounded drugs are covered only if the requirements listed under the Exclusions section of this section are met. If a compounded medication is approved for coverage, the Non-Formulary Brand Drug Copayment applies. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. You or your Physician may request prior authorization by submitting supporting information to the Claims Administrator. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within five business days or within 72 hours for an expedited review, unless state or federal law requires the prior authorization be completed within a shorter timeframe.

Limitation on Quantity of Drugs that may be Obtained Per Prescription or Refill

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Copayment will be assessed. Some prescriptions are limited to a maximum allowed quantity based on Medical Necessity and appropriateness of therapy as determined by the Claims Administrator's Pharmacy and Therapeutics Committee.

2. Designated Specialty Drugs may be dispensed for a 15-day trial at a pro-rated Copayment or Coinsurance for an initial prescription, and with the Member's agreement. This Short Cycle Specialty Drug Program allows the Member to obtain a 15-day supply of their prescription to determine if they will tolerate the Specialty Drug before obtaining the complete 30-day supply, and therefore helps save the Member out-of-pocket expenses. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the Short Cycle Specialty Drug Program, which the Member can elect at that time. At any time, either the Member, or Provider on behalf of the Member, may choose a full 30-day supply for the first fill. If the Member has agreed to a 15-day trial, the Network Specialty Pharmacy will also contact the Member before dispensing the remaining 15-day supply to confirm if the Member is tolerating the Specialty Drug. To find a list of Specialty Drugs in the Short Cycle Specialty Drug Program, the Member may visit https://blueshieldca.com/uc or call the toll-free Customer Service number on your Identification Card.

3. Drugs through UC Maintenance Drug Program are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dis-

pensed, and refill authorizations cannot be combined to reach a 90-day supply.

4. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.
5. Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
6. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions

No benefits are provided under the Outpatient Prescription Drug Benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of your Benefit Booklet – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Any drug provided or administered while the Member is an Inpatient, or in a Physician's office, Skilled Nursing Facility, or Outpatient Facility (see the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Benefit Booklet);
2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facility (see the Hospital Benefits (Facility Services) and Skilled Nursing Facility Benefits sections of your Benefit Booklet);
3. Drugs (except as specifically listed as covered under this Outpatient Prescription Drug Benefit), drugs which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
4. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
5. Drugs that are considered to be experimental or investigational;
6. Medical devices or supplies except as specifically listed as covered herein (see the Durable Medical Equipment Benefits, Orthotics Benefits, and Prosthetic Appliances Benefits sections of your Benefit Booklet)**.** This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;
7. Blood or blood products (see the Hospital Benefits (Facility Services) section of your Benefit Booklet);
8. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
9. Dietary or Nutritional Products (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits sections of your Benefit Booklet);
10. Any drugs which are not self-administered. These medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits and Family Planning Benefits sections of the health plan;
11. All Drugs for the treatment of infertility;
12. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from the Claims Administrator;
13. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) are ordered by a Physician, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered. Note: refer to your medical Benefits for coverage of other contraceptive methods;
14. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered, and (4) medical literature supports its use for requested diagnosis;
15. Replacement of lost, stolen or destroyed prescription Drugs;
16. For Members enrolled in a Hospice Program through a Participating Hospice Agency only pharmaceuticals that are medically necessary for the palliation and management of terminal illness and related conditions are excluded from coverage under the Outpatient Prescription Drug Benefits, and are covered under the Hospice Program Benefits;
17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection, medications prescribed to treat pain, or drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints;
18. Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list, except for a covered Emergency;
19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;
20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription com-

ponents. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs;

21. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

22. Drugs used for the treatment of sexual dysfunctions and sexual inadequacies, regardless of the presence of organically based conditions.

NOTES

For claims submission and information contact the Claims Administrator.

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540

Participants may call Customer Service toll free,

Monday through Friday, 7 a.m.-7 p.m.: 1-855-201-8375

The hearing impaired may call Customer Service through the toll-free TTY number: 1-800-241-1823

Benefits Management Program Telephone Numbers

For Prior Authorization: Please call the Customer Service telephone number indicated on the back of the Member's identification card

For prior authorization of Benefits Management Program Radiological Services: 1-888-642-2583

Please refer to the Benefits Management Program section of this booklet for information.