

UNIVERSITY OF CALIFORNIA

Effective January 1, 2018

UC Medicare PPO without Prescription Drugs

Plan ID#280509

Benefit Booklet

This Benefit Booklet provides a complete explanation of the terms and conditions of coverage for your UC Medicare PPO without Prescription Drugs Plan. Be sure you understand the Benefits offered under this Plan before receiving services.

Benefits of this Plan are available only for Covered 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 the Covered Services or supplies furnished on or after the Effective Date of modification. There is no vested right to receive the Benefits of this Plan.

Many words used in this Benefit Booklet have special meanings (e.g., Covered Services and Medically Necessary). These words are capitalized and are defined in the "DEFINITIONS" section. See these definitions for the best understanding of what is being stated. Throughout this Benefit Booklet you may also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" refers to Anthem, the Claims Administrator. The Plan Administrator is the University of California Executive Steering Committee on Health Benefits Programs, which has delegated certain duties to Anthem Blue Cross Life and Health Insurance Company (Anthem). The words "you" and "your" mean the Member, Employee and each covered Dependent. **All capitalized words in this document are defined in the DEFINITIONS section of this booklet starting at page 45.**

Please read this Benefit Booklet carefully so that you understand all the Benefits your Plan offers. Keep this Benefit Booklet handy in case you have any questions about your coverage. This Booklet, the University of California Group Insurance Regulations (Medical-related portions) and applicable fact sheets constitute both the Plan document and summary for the Plan.

Important: The Regents of the University of California is the Employer and may change or terminate the Plan by action of the Plan Administrator. Anthem Blue Cross Life and Health Insurance Company has been appointed the Claims Administrator. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross processes and reviews the claims submitted under this Plan. This is not an insured benefit plan. The Benefits described in this Benefit Booklet or any rider or amendments are funded by, and paid out of the asset of the Employer who is responsible for their payment and retiree contributions. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved in accordance with the Plan's grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, Anthem will provide a Complaint Form which you may use to explain the matter.

All grievances received under the Plan will be acknowledged in writing, together with a description of how the Plan proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

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SUMMARY OF BENEFITS

Note: This Plan is a complement to your existing Medicare Part A and Part B Plan. Only services and supplies that Medicare determines to be allowable and Medically Necessary are covered under this Supplement Plan except when specifically identified. Medicare Benefits are primary and then the Benefits of this Plan are calculated to coordinate up to the Medicare allowable amount. For services and supplies which Medicare does not cover, the Plan will provide Benefits as outlined below under the summary below titled SUMMARY OF ADDITIONAL BENEFITS – NON-MEDICARE COVERED SERVICES.

Each year the U.S. Department of Health and Human Services publishes a Medicare handbook entitled Medicare & You. This handbook outlines the Benefits Medicare Part A and Part B provide and includes any changes in Deductibles, Copayments, or Benefits that may occur from year to year. To obtain a copy, contact your nearest Social Security office, visit the web site www.medicare.gov or call 1-800-MEDICARE.

The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this booklet carefully and Medicare & You (the handbook describing Medicare benefits) for specific information on benefits, limitations and exclusions.

Many words used in this Benefit Booklet have special meanings (e.g., Covered Services and Medically Necessary). These words are capitalized and are defined in the "DEFINITIONS" section starting at page 45.

Member Calendar Year Deductible for Medicare and Non-Medicare Covered Services	Deductible Responsibility	
Calendar Year Medical Deductible	Services by Preferred, Participating, and Other Providers	Services by Non-Preferred and Non-Participating Providers
Applies to non-Medicare Covered Services covered by this Plan and to Medicare Covered Services not paid by Medicare but paid by this Plan	\$100 per Member	

Member Maximum Calendar Year Out-of-Pocket Responsibility for Medicare and Non-Medicare Covered Services	Member Maximum Calendar Year Out-of-Pocket Responsibility	
	Services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers	
Calendar Year Out-of-Pocket Maximum Applies to: <ul style="list-style-type: none"> • Member Copayments and Deductibles within Medicare allowable amounts for Medicare Covered Services • The Plan's Maximum Allowed Amounts for non-Medicare Covered Services • Medicare covered services not paid by Medicare but paid by this Plan Note: This Plan does not include coverage for prescription drugs	\$1,500 per Member	

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

SUMMARY OF SUPPLEMENTAL MEDICARE BENEFITS

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

A Benefit Period begins on the first day you receive Covered Services as an inpatient in a Hospital and ends after you have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row.

Benefit ¹	Medicare Pays (in 2018)	Plan Pays	Member Pays
Medicare Part A^{2, 3, 4}			
Hospitalization – Semi-private room and board, general nursing and miscellaneous services and supplies.			
• First 60 days	All but \$1,340	\$1,340 (Part A Deductible ²)	\$0
• 61st through 90th day	All but \$335 a day	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
• 91st day and after while using 60 lifetime reserve days	All but \$670 a day	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
• Once lifetime reserve days are used – additional days	\$0	80% of Medicare Eligible Expenses	20% of Medicare Eligible Expenses
• Beyond the additional 365 days Please refer to the section, “Additional Benefits and Coverages (Covered Services) Not Covered by Medicare” for Hospital coverage after you have exhausted both the Medicare lifetime reserve days and the additional 365 day hospitalization benefit.	\$0	80% of Medicare Eligible Expenses	20% of Medicare Eligible Expenses
Skilled Nursing Facility Care⁵ – Must meet Medicare’s requirements including having been in a Hospital at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.			
• First 20 days	All approved amounts	\$0	\$0
• 21st through 100th day	All but \$167.50 a day	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
• 101st day and after	\$0	\$0	You pay all the costs
Blood⁶			
• First 3 pints	\$0	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
• Additional amounts	100%	\$0	\$0

Benefit ¹	Medicare Pays (in 2018)	Plan Pays	Member Pays
Medicare Part A^{2, 3, 4}			
Hospice Care			
<ul style="list-style-type: none"> Must meet Medicare's requirements, including Physician's certification of terminal illness 	All but very limited Copayment for outpatient drugs and inpatient respite care	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses

MEDICARE (PART B) – MEDICARE SERVICES PER CALENDAR YEAR

Benefit¹	Medicare Pays (in 2018)	Plan Pays	Member Pays
Medicare Part B^{3, 7}			
<ul style="list-style-type: none"> Ambulance Services <p>Emergency ground transportation to a Hospital or Skilled Nursing Facility for Medically Necessary services when transportation in any other vehicle could endanger your health. Medicare will pay for transportation in an airplane or helicopter if you require immediate and rapid ambulance transportation that ground transportation can't provide.</p>	80%	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses ⁷
Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment⁷ – Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
<ul style="list-style-type: none"> First \$183 of Medicare approved amounts (Deductible)⁷ 	\$0	Up to \$183 (Part B Deductible ⁷)	\$0
<ul style="list-style-type: none"> Remainder of the Medicare approved amounts 	Generally 80%	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
<ul style="list-style-type: none"> Part B Excess Charges (above the Plan's Maximum Allowed Amount) 	\$0	\$0	You pay all the costs
Blood⁶			
<ul style="list-style-type: none"> First 3 pints 	\$0	80% of Medicare Eligible Expenses	20% of Medicare Eligible Expenses
<ul style="list-style-type: none"> Next \$183 of Medicare approved amounts⁷ 	\$0	Up to \$183 (Part B Deductible ⁷)	\$0
<ul style="list-style-type: none"> Remainder of Medicare approved amounts 	80%	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
Clinical Laboratory Services			
<ul style="list-style-type: none"> Tests for diagnostic services 	80%	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
Home Health Care (Medicare Approved Services)			
<ul style="list-style-type: none"> Medically Necessary skilled care services and medical supplies 	100%	\$0	\$0

Benefit¹	Medicare Pays (in 2018)	Plan Pays	Member Pays
Medicare Part B^{3,7}			
Durable Medical Equipment⁸ – Covered equipment or supplies and replacement or repair services must be obtained from a Medicare approved supplier for Medicare to pay.			
• First \$183 of Medicare approved amounts (Deductible) ⁷	\$0	Up to \$183 (Part B Deductible ⁷)	\$0
• Remainder of the Medicare approved amounts	80%	80% of remaining Medicare Eligible Expenses	20% of remaining Medicare Eligible Expenses
• Part B Excess Charges (above the Plan's Maximum Allowed Amount)	\$0	\$0	You pay all the costs

Medicare Covered Services Footnotes

1. Only Retired Employees and their Spouses or Domestic Partners enrolled in Medicare Parts A & B are eligible for this Medicare PPO Plan. Medicare will always pay primary for Medicare covered services. The Plan will coordinate with Medicare, paying secondary.
2. The Part A Deductible of \$1,340 applies to Covered Services and items for Hospital inpatient care, Skilled Nursing Facility care, home health care, Hospice care and blood. The Deductible must be paid before Medicare begins providing payment for these Part A Covered Services. The Medicare PPO Plan pays the Part A Deductible for you.
3. A Member may select any licensed Physician, Provider, or Hospital that accepts Medicare, for treating a covered illness or injury within the United States. This Plan will always pay secondary to Medicare for Medicare covered services. The Plan will pay secondary using Medicare allowed amounts subtracting the Medicare Part A or Part B Deductible where applicable and the amount paid by Medicare.
4. A Benefit Period begins on the first day you receive service as an inpatient in a Hospital and ends after you have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row.
5. The “Skilled Nursing Facility Care Benefit” is measured in Benefit Period. A Benefit Period is defined as 100 days or less of confinement in an approved Medicare facility, and the Benefit is subject to preconditions before Medicare approves the care.
6. For blood covered by Medicare Part A, in most cases, the Hospital gets blood from a blood bank at no charge, and you won’t have to pay for it or replace it. If the Hospital has to buy blood for you, Anthem will pay the Hospital costs for the first 3 units of blood you get in a Calendar Year or you can have the blood donated by you or someone else. For blood covered under Medicare Part B, in most cases, the Provider gets blood from a blood bank at no charge, and you won’t have to pay for it or replace it. If the Provider has to buy blood for you, Anthem will pay 80% of the Provider costs for the first 3 units of blood you get in a Calendar Year or you can have the blood donated by you or someone else. After the first 3 units of blood, Medicare will pay 80% of approved amounts and Anthem will pay 80% of the remaining eligible amount and you pay 20% of the remaining eligible amount.
7. The Part B Deductible of \$183 applies to Covered Services and items for doctor’s services, Hospital outpatient care, home health, Preventive Care Services and durable equipment. The Deductible must be paid before Medicare begins providing payment for these Part B Covered Services. The Medicare PPO Plan pays the Part B Deductible for you.
8. Durable medical equipment must be obtained from a Medicare-approved supplier for Medicare to pay. They are listed at www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633-4227 and for TTY users 1-877-486-2048.

SUMMARY OF ADDITIONAL BENEFITS – NON-MEDICARE COVERED SERVICES

ADDITIONAL BENEFITS AND COVERAGES (COVERED SERVICES) NOT COVERED BY MEDICARE

The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of Covered Services and exclusions of the Plan.

See the end of this SUMMARY OF BENEFITS for important Benefit notes.

Benefit	Member Pays ¹		
	Medicare Pays	Services by Preferred, Participating, and Other Providers ²	Services by Non-Preferred and Non-Participating Providers ³
Acupuncture Benefits			
<ul style="list-style-type: none"> Acupuncture services – office location <p>The <i>plan</i> will pay for up to 24 visits per Member during a Calendar Year.</p> <p>Note: Services are not covered by Medicare</p>	\$0	20%	20%
Exhausted Medicare Benefits			
<ul style="list-style-type: none"> When you have reached a Medicare Benefit limit or reached a cap limit, the Plan may provide additional benefits. Please refer to “Additional Benefits and Coverages (Covered Services) Not Covered by Medicare” section. 	\$0	20%	20%
Hearing Aid Benefits			
<ul style="list-style-type: none"> Hearing Aid(s) <p>Benefits will be provided for two hearing aids per 36-months.</p> <p>Note: Services are not covered by Medicare</p>	\$0	20%	20%

Benefit	Member Pays ¹		
	Medicare Pays	Services by Preferred, Participating, and Other Providers ²	Services by Non-Preferred and Non-Participating Providers ³
Hospital Benefits (Facility Services)⁴			
<ul style="list-style-type: none"> Inpatient services and supplies, provided by a Hospital <p>When you have used all of your Medicare Part A Benefit days during a Benefit Period and all of your Medicare lifetime reserve days are exhausted, the Plan will provide additional Hospital Benefits for the remainder of that Benefit Period.</p> <p>Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews after Medicare Benefits are exhausted.</p>			
– Facility fees - once lifetime reserve days are used – additional days	\$0	20%, if authorized	20%, if authorized
– Facility fees - beyond the additional 365 days	\$0	20%, if authorized	20%, if authorized
Mental Health Conditions and Substance Abuse			
<ul style="list-style-type: none"> Inpatient services and supplies, provided by a Hospital <p>Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews after Medicare Benefits are exhausted. Medicare may apply different limitations on Mental Health and/or Substance Abuse services; please refer to Medicare for a complete set of Medicare guidelines.</p>			
– Facility fees - once lifetime reserve days are used – additional days	\$0	20%, if authorized	20%, if authorized
– Facility fees - beyond the additional 365 days	\$0	20%, if authorized	20%, if authorized
– Outpatient Partial Hospitalization	\$0	20%, if authorized	20%, if authorized
– Inpatient Residential Treatment	\$0	20%, if authorized	20%, if authorized

Benefit	Member Pays ¹		
	Medicare Pays	Services by Preferred, Participating, and Other Providers ²	Services by Non-Preferred and Non-Participating Providers ³
<ul style="list-style-type: none"> Outpatient office visits Includes office visits with all licensed behavioral health Providers, including psychiatrists, psychologists, Marriage, Family and Child Counselors (MFT, MFCC) 	\$0	20%	20%
Service Outside the United States (Emergency and non-Emergency care)			
Members can receive Covered Services outside of California and outside the United States through Anthem's BlueCard Program. See the "Inter-Plan Arrangements" provision under the GENERAL PROVISIONS section for additional information.	\$0	20%	20%
Transgender Benefits			
<ul style="list-style-type: none"> Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews. 			
- Hospital inpatient services		20%, if authorized	20%, if authorized
- Hospital outpatient surgery services		20%, if authorized	20%, if authorized
- <i>Physician</i> services		20%, if authorized	20%, if authorized
Travel Immunizations Benefits			
- Hepatitis A	\$0	20%	20%
- Hepatitis B	\$0	20%	20%
- Meningitis	\$0	20%	20%
- Polio	\$0	20%	20%
- Japanese Encephalitis	\$0	20%	20%
- Rabies	\$0	20%	20%
- Typhoid	\$0	20%	20%
- Yellow Fever	\$0	20%	20%

Additional Benefits and Services Not Covered by Medicare Footnotes

1. Unless otherwise specified, Copayment are calculated based on the Maximum Allowed Amount.
2. Other Providers are not Preferred Providers and so for services by Other Providers, you are responsible for all charges above the Maximum Allowed Amount. Other Providers include acupuncturists, nursing homes and certain labs (see the DEFINITIONS section on page 45).
3. For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Maximum Allowed Amount.
4. When you have used all of your Medicare Part A benefit days during a Benefit Period and of your Medicare lifetime reserve days are exhausted, the Plan will provide additional Hospital Benefits for the remainder of that Benefit Period.

INTRODUCTION

Your Employer has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include pre-service review and utilization management requirements, coordination of Benefits, timely filing limits, and other requirements to administer the Benefits under this Plan.

The medical plan described in this Benefit Booklet complements your Medicare Plan. It also pays for some expenses not covered by Medicare when Anthem determines such expense is Incurred for services and supplies that are Medically Necessary. The fact that a Physician prescribes or orders a service does not, in itself, mean that the service is Medically Necessary or that the service is covered under this Plan. Consult this Benefit Booklet or contact Anthem Health Guide toll free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) if you have any questions regarding whether services are covered.

This Plan contains many important terms (such as "Medically Necessary" and "Maximum Allowed Amount") that are defined in the DEFINITIONS section starting at page 45. When reading through this booklet, consult the DEFINITIONS section to be sure that you understand the meaning of these words.

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

Choice of Providers and Payment of Claims for Covered Medicare Services. A Member may select any licensed Physician, Provider, or Hospital that accepts Medicare, for treating a covered illness or injury within the United States. This Plan will always pay secondary to Medicare for Medicare covered services. The Plan will pay secondary using Medicare allowed amounts subtracting the Medicare Part A or Part B Deductible where applicable and the amount paid by Medicare. Providers are paid by Anthem only for the Covered Services they render to Plan Members. Providers receive no financial incentives or bonuses from Anthem.

If the Physician, Provider, or Hospital accepts the Medicare assignment method of payment, Anthem's payment as secondary payor will not be more than the difference between Medicare's allowable charge and the amount paid by Medicare.

Claims are submitted for payment after Services are received. Requests for payments must be submitted to Anthem by the medical Provider or Members within one year after the month in which *services* are rendered or the date of processing of Medicare Benefits. The claim must include itemized evidence of charges Incurred together with the documentary evidence of the action taken relative to such charges by the Department of Health and Human Services under Medicare.

Anthem will send you an Explanation of Benefits notice showing what was paid, and what, if anything, the Member owes.

The Member may have to pay for Benefits for *services* not covered by Medicare, except for those Benefits and *services* as stated under the section of this booklet, "Additional Benefits and Coverages (Covered Services) Not Covered by Medicare." Anthem will provide payment to the Member upon receipt of a properly completed claim form within one (1) year after the month in which Services are rendered. All requests for payments and claim forms are to be sent to Anthem.

No sums payable hereunder may be assigned without the written consent of Anthem. This prohibition shall not apply to ambulance *services* or certain Medicare Providers as required by section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) for which Anthem shall provide payment directly to the Provider.

Medicare Private Contracting Provision and Providers Who Do Not Accept Medicare. Federal Legislation allows Physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these Physicians or practitioners will need to enter into written "private contracts" with these Physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical Providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

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

If you are classified as a retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more Physicians or practitioners, or if you choose to obtain services from a Provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these Physicians or other practitioners. In either case, no Benefits will be paid by this Plan for services rendered by these Physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

Therefore, it is important that you confirm that your Provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

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

Preferred Providers for Additional Benefits and Services Not Covered by Medicare. This Plan is specifically designed for you to use Anthem's Preferred Providers. Preferred Providers include certain Physicians, Hospitals, alternate care services Providers, and Other Providers. Preferred Providers are listed in the Preferred Provider directories. All Anthem 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. A directory of Preferred Providers is available upon request. You may call Anthem Health Guide toll free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) and request for a directory to be sent to you.

To determine whether a Provider is a Preferred Provider, consult the directory. You may also verify this information by accessing Anthem's internet site located at www.anthem.com/ca, or by calling the Anthem Health Guide at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). **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 the 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 Anthem for services.

Preferred Providers agree to accept Anthem'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 Subrogation and Reimbursement provision. 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 Subrogation and Reimbursement provision.

Anthem 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 Anthem Health Guide **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

If you go to a Non-Preferred Provider, Anthem's payment for a service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount Anthem pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Directories of Preferred Providers located in your area have been provided to you. Extra copies are available from Anthem. If you do not have the directories, please contact Anthem immediately and request a copy. You may call Anthem Health Guide toll free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) and request for a directory to be sent to you.

Second Opinions. If you have a question about your condition or about a Plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit will be provided according to the Benefits, limitations, and exclusions of this Plan.

Triage or Screening Services. If you have questions about a particular health condition or if you need someone to help you determine whether or not care is needed, triage or screening services are available to you by telephone. Triage or screening services are the evaluation of your health by a Physician or a nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the 24/7 NurseLine at the telephone number listed on your identification card 24 hours a day, 7 days a week.

After Hours Care. After hours care is provided by your Physician who may have a variety of ways of addressing your needs. You should call your Physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive non-Emergency care and non-Urgent Care within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an Emergency, call 911 or go to the nearest emergency room.

All Benefits are subject to coordination with Benefits. Please refer to the COORDINATION OF BENEFITS section of this booklet for details.

The Benefits of this Plan are subject to the SUBROGATION AND REIMBURSEMENT section.

YOUR MEDICAL BENEFITS

Calendar Year Deductible for Medicare and Non-Medicare Services

The Calendar Year Deductible per Member is shown on the SUMMARY OF BENEFITS. The Deductible applies to Non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by Anthem.

This Plan will pay for Covered Services once the per Member Calendar Year Deductible amount as shown on the SUMMARY OF BENEFITS is satisfied. This Deductible must be made up of charges covered by the Plan. Charges in excess of the Maximum Allowed 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. **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.

Maximum Calendar Year Out-of-Pocket Responsibility for Medicare and Non-Medicare Services

After you have met the total out-of-pocket payments as shown in the SUMMARY OF BENEFITS for Copayments and Deductibles you incur during a Calendar Year, you will no longer be required to pay a Copayment for the remainder of that year, but you remain responsible for costs in excess of the Maximum Allowed Amount.

Applicable to all medical Plan Member liability within Medicare allowable amount for Medicare covered services and the Maximum Allowed Amounts for non-Medicare covered services and Medicare covered services not paid by Medicare but paid by Anthem, including the Plan Deductible.

The per Member 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 Maximum Allowed Amount for that Member's Covered Services for the remainder of that Calendar Year.

Charges for Services which are not covered, charges above the Maximum Allowed Amount, and charges in excess of the amount covered by the Plan are the Member's responsibility and are not included in the maximum Calendar Year out-of-pocket responsibility.

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

Maximum Allowed Amount

This section describes the term Maximum Allowed Amount as used in this Benefit Booklet, and what the term means to you when obtaining Covered Services under this Plan. The Maximum Allowed Amount is the total reimbursement payable under your Plan for Covered Services you receive. It is the Plan's payment towards the service billed by a Hospital, Physician or Other Health Care Provider combined with any Deductible or Copayment owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Calendar Year Deductible under this Plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. You may be billed by the Hospital, Physician or Other Health Care Provider for the difference between its charges and the Maximum Allowed Amount. In many situations, this difference could be significant.

When you receive Covered Services, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted. Anthem uses these rules to evaluate the claim information and determine the accuracy

and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if Anthem determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your Physician submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the Maximum Allowed Amount will be based on the single procedure code.

Type of Provider. For Covered Services performed by a Hospital, Physician or Other Health Care Provider, the Maximum Allowed Amount for this Plan will be based on Anthem's applicable rate or fee schedule for this Plan, an amount negotiated by Anthem or a third party vendor which has been agreed to by the Hospital, Physician or Other Health Care Provider, an amount derived from the total charges billed, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually.

Providers who are contracted for other products with Anthem may have provisions in their contracts that affect the Maximum Allowed Amount for this Plan and for other products for which they are not contracted. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Physicians, Hospitals, and Other Health Care Providers may send you a bill and collect for the amount of the Physician's, Hospital's, or Other Health Care Provider's charge that exceeds the Maximum Allowed Amount under this Plan.

Exception: If Medicare is the primary payor, the Maximum Allowed Amount does not include any charge:

1. By a Hospital, in excess of the approved amount as determined by Medicare; or
2. By a Physician or Other Health Care Provider, in excess of the lesser of the Maximum Allowed Amount stated above, or:
 - a. For Providers who accept Medicare assignment, the approved amount as determined by Medicare; or
 - b. For Providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

You will always be responsible for expense Incurred which is not covered under this Plan.

Conditions of Coverage

The following conditions of coverage must be met for expense Incurred for services or supplies to be covered under this Plan.

1. You must incur this expense while you are covered under this Plan. Expense is Incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in the "Additional Benefits and Coverages (Covered Services) Not Covered by Medicare" section. Additional limits on covered charges are included under specific Benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in the "Exclusions and Limitations" section. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this Plan.

5. The expense must not exceed any of the maximum Benefits or limitations of this Plan.
6. Any services received must be those which are regularly provided and billed by the Provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a Physician.

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 Anthem 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 Anthem within one (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, Member's number, a copy of the Provider's billing showing the Services rendered, dates of treatment and the patient's name. Anthem 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 Member Claim form to Anthem Blue Cross, P.O. Box 60007 Los Angeles, CA, 90060-0007.

To obtain a claim form you or someone on your behalf may call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or go to the website at www.anthem.com/ca and download and print one. If necessary, you may use a photocopy of the claim form.

Medicare Benefits and Coverages (Covered Services)

For more information on what Benefits are covered by Original Medicare (Parts A and B) consult the latest version of the **Medicare and You** handbook developed by the U.S. Centers for Medicare and Medicaid Services (CMS). You can visit CMS website at www.medicare.gov or call the toll-free number 1-800-633-4227. TTY users should call 1-877-486-2048.”

Please review this Evidence of Coverage and Medicare & You (the handbook describing Medicare Benefits) for specific information on benefits, limitations and exclusions. Benefits provided by this Plan (but only to the extent they are not hereafter excluded) are for the necessary treatment of any sickness or Accidental Injury as follows:

MEDICARE PART A

This Plan will pay for the following:

Hospitalization

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible Amount per Benefit Period.

Room and board charges shall be no more than the charge for a semi-private accommodation in the Hospital of confinement, unless confinement in a subacute Skilled Nursing Facility or private room is certified as Medically Necessary by an attending Physician.

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;

Coverage of Part A Medicare Eligible Expenses Incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime Inpatient reserve day used. Each Medicare beneficiary is given sixty (60) lifetime reserve days which begin from the 91st day and after;

Upon exhaustion of the Medicare Hospital Inpatient coverage including the sixty (60) lifetime reserve days, coverage for the Medicare Part A Eligible Expenses for hospitalization will be paid at the appropriate standard of payment which has been approved by Medicare, subject to a lifetime maximum benefit of an additional 365 days (except that psychiatric care in a psychiatric Hospital participating in the Medicare program is limited to 190 days during the Member’s lifetime);

Note: 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.

Skilled Nursing Facility Care

Skilled Nursing Facility Care Covered Services for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care, including subacute care, eligible under Medicare Part A.

Blood

Coverage for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Hospice

This Plan will provide coverage for Hospice care which includes cost sharing for all Part A Medicare eligible Hospice care and respite care expenses.

MEDICARE PART B

This Plan will pay for the following:

Coverage for the coinsurance amount or, in the case of Hospital Outpatient Services, the co-payment amount of Medicare Eligible Expenses under Part B regardless of Hospital confinement, provided the Member is receiving concurrent benefits from Medicare for the same Services.

Benefits for the coverage listed above shall be paid when the Member is not entitled to payment for such Services under Medicare by reason of exhaustion of Medicare Benefits or reductions for coinsurance and Deductibles required under Medicare.

Blood

Coverage for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations. For additional blood after the first three (3) pints, the Plan will pay the \$183.00 Part B Deductible plus 20% of Medicare Approved Amounts.

Durable Medical Equipment

Plan will pay the \$183.00 Part B Deductible plus 80% of the remainder charges of Medicare approved charges. The Member is responsible for all costs for Part B excess charges (above Plan approved amounts).

Additional Benefits and Coverages (Covered Services) Not Covered by Medicare

Acupuncture Benefits. The services of a Physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The Plan will pay for up to 24 visits during a Calendar Year.

Breast Health Screening (Athena). Covered Members who receive mammography screening are eligible to complete a breast health screening tool which provides additional information on the risk of developing breast cancer. High risk individuals may receive telephonic or in person counseling from an Athena breast health specialist. For further information on the Athena program, please go to the following website: www.wisdomstudy.org.

Exhausted Medicare Benefits. The Plan will provide extended coverage for Medicare covered services when a Member has exhausted the Medicare benefit and a Medicare approved extension is also exhausted, or a Medicare extension is not available for that specific service. Anthem will provide extended coverage through the end of the Calendar Year as primary, provided all of the following criteria have been satisfied:

1. Medicare Explanation of Benefit (EOB) coding states denied – Medicare benefit has been exhausted.
2. Medicare appeal for coverage extension has been exhausted or no additional Medical extension is available for the service. (If an extension is available but Medicare denies the Physician requested extension, no further coverage is payable through Anthem.)
3. Services determined to be Medically Necessary and appropriate will be covered as Plan benefits.

Hearing Aid Benefits. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. Benefits will be provided for two hearing aids every 36-months.

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

No Benefits will be provided for the following:

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

Hospital Benefits. After all Medicare Part A Benefit days are exhausted and Medicare lifetime reserve days are exhausted, this Plan will provide additional Hospital Benefits for the remainder of the Benefit Period.

1. Inpatient services and supplies, provided by a Hospital. The Maximum Allowed Amount will not include charges in excess of the Hospital's prevailing two-bed room rate unless there is a negotiated per diem rate between Anthem and the Hospital, or unless your Physician orders, and Anthem authorizes, a private room as Medically Necessary.
2. Services in Special Care Units.
3. Outpatient services and supplies provided by a Hospital, including outpatient surgery.

Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews after Medicare Benefits are exhausted.

Mental Health Conditions and Substance Abuse Benefits. After all Medicare Part A Benefit days are exhausted and Medicare lifetime reserve days are exhausted, this Plan will provide additional Hospital Benefits for the remainder of the Benefit Period. This Plan provides coverage for the Medically Necessary treatment of Mental Health Conditions and substance abuse. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section.

Services for the treatment of Mental Health Conditions and substance abuse covered under this Plan are subject to the same Deductibles and Copayments that apply to services provided for other covered medical conditions and prescription drugs.

Covered Services shown below for the Medically Necessary treatment of Mental Health Conditions and substance abuse, or to prevent the deterioration of chronic conditions.

1. Inpatient Hospital Services and services from a Residential Treatment Center (including crisis residential treatment) as stated in the "Hospital" provision of this section, for inpatient services and supplies, and Physician visits during a covered inpatient Stay.
2. Outpatient Office Visits for the following:
 - individual and group mental health evaluation and treatment,
 - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
 - drug therapy monitoring,
 - individual and group chemical dependency counseling,
 - medical treatment for withdrawal symptoms,
 - methadone maintenance treatment,
 - Behavioral health treatment for pervasive developmental disorder or autism delivered in an office setting.
- Other Outpatient Items and Services:
 - Partial hospitalization, including Intensive Outpatient Programs and visits to a Day Treatment Center. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies,
 - Psychological testing,
 - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
 - Behavioral health treatment for pervasive developmental disorder or autism delivered at home.
3. Behavioral health treatment for pervasive developmental disorder or autism. Inpatient services, office visits, and other outpatient items and services are covered under this section. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this Plan (see Medicare for details).
4. Diagnosis and all Medically Necessary treatment of Severe Mental Disorder of a person of any age and serious emotional disturbances of a child.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the "Preventive Care Benefits". Please see that provision for further details

Transgender Benefits. Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to Plan Benefits that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Plan's prescription drug benefits (if such Benefits are included).

Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Travel Immunization Benefits. The following vaccinations are covered.

- Hepatitis A
- Hepatitis B
- Meningitis
- Polio
- Japanese Encephalitis
- Rabies
- Typhoid
- Yellow Fever

Exclusions and Limitations

No payment will be made under this Plan for services or supplies that are not Medically Necessary or that were Incurred before the Member's Effective Date or after a Member's coverage has ended in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.) The following services are limited or excluded from all Benefits unless otherwise stated in the Plan or any endorsements. For more information on what Benefits are covered by Original Medicare (Parts A and B) consult the latest version of the **Medicare and You** handbook developed by the U.S. Centers for Medicare and Medicaid Services (CMS). You can visit CMS website at www.medicare.gov or call the toll-free number 1-800-633-4227. TTY users should call 1-877-486-2048.

Acupuncture. Acupuncture treatment except as specifically stated under "Acupuncture Benefits" in the "Additional Benefits and Coverages (Covered Services) Not Covered by Medicare" section. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

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

This exclusion does not apply to Medically Necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria is met as recommended by the Plan's medical policy.

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

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

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change or physical therapy. Custodial Care and rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth;
- Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- Services which are required by law to be covered;
- Services specified as covered in this Benefit Booklet;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Educational or Academic Services. This Plan does not cover:

1. Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
2. Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
3. Academic or educational testing.
4. Teaching skills for employment or vocational purposes.
5. Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
6. Teaching manners and etiquette or any other social skills.
7. Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

Excess Amounts. Any amounts in excess of Maximum Allowed Amounts or any medical benefit maximum.

Experimental or Investigative. Any Experimental or Investigative procedure or medication. But, if you are denied Benefits because it is determined that the requested treatment is Experimental or Investigative, you may request that the denial be reviewed.

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

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

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Government Treatment. Any services you actually received that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this Plan is expressly required by federal or state law. The Plan will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this Plan.

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

Hearing Aids or Tests. Hearing aids, except as specifically stated under "Hearing Aid Benefits" in the "Additional Benefits and Coverages (Covered Services) Not Covered by Medicare" section.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of Infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

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

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

Medical Equipment, Devices and Supplies. This Plan does not cover the following:

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Enhancements to standard equipment and devices that is not Medically Necessary.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation.

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

Not Medically Necessary. Services or supplies that are not Medically Necessary, as defined. See page 45 in the DEFINITIONS section for more information.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses.

Orthodontia. Braces and other orthodontic appliances or services.

Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes.

Outpatient Occupational Therapy. Outpatient occupational therapy unless otherwise stated in the Plan.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin. Cosmetics, health or beauty aids.

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

Physical Therapy or Physical Medicine. Services of a Physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement unless otherwise stated in the Plan

Private Contracts. Services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act, except for outpatient office visits specifically stated in the "Mental Health Conditions and Substance Abuse Benefits" in the "Additional Benefits and Coverages (Covered Services) Not Covered by Medicare" section.

Private Duty Nursing. Private duty nursing services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority.

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

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

Speech Therapy. Speech therapy except unless otherwise stated in the Plan.

Sterilization Reversal. Reversal of an elective sterilization.

Telephone, Facsimile Machine, and Electronic Mail Consultations. Consultations provided using telephone, facsimile machine, or electronic mail.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

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

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

Waived Cost-Shares Out-of-Network Provider. For any service for which you are responsible under the terms of this Plan to pay a Copayment or Deductible, and the Copayment or Deductible is waived by an Out-of-Network Provider.

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

SUBROGATION AND REIMBURSEMENT

These provisions apply when the plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the plan to exercise the plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fails to do whatever is necessary to enable the plan to exercise its subrogation rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- The plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the plan's subrogation claim and any claim held by you, the plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

Reimbursement

If you obtain a Recovery and the plan has not been repaid for the benefits the plan paid on your behalf, the plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the plan from any Recovery to the extent of benefits the plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the plan shall have a right of full recovery, in first priority, against any Recovery. Further, the plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the plan's equitable lien applies is a plan asset.

- Any Recovery you obtain must not be dissipated or disbursed until such time as the plan has been repaid in accordance with these provisions.
- You must reimburse the plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.
- If you fail to repay the plan, the plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the plan has paid or the amount of your Recovery whichever is less, from any future benefit under the plan if:
 1. The amount the plan paid on your behalf is not repaid or otherwise recovered by the plan; or
 2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the plan, the plan shall be entitled to deduct the amount of the plan's lien from any future benefit under the plan.
- The plan shall also be entitled to recover any of the unsatisfied portion of the amount the plan has paid or the amount of your Recovery, whichever is less, directly from the providers to whom the plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the plan will not have any obligation to pay the Provider or reimburse you.
- The plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by the plan.
- You must cooperate with the plan in the investigation, settlement and protection of the plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the plan to exercise its subrogation or reimbursement rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- You must not do anything to prejudice the plan's rights.
- You must send the plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The plan has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person that Recovery shall be subject to this provision.

The plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

COORDINATION OF BENEFITS

If you are covered by more than one group medical plan, your benefits under this plan (referred to as “This Plan” under this section) will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each member, per calendar year, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below. Contact Medicare at 1-800-MEDICARE for your coordination of benefit questions when enrolled or enrolling in multiple plans.

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not an Allowable Expense.

The following are not Allowable Expenses:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a member pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

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

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

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

- a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.
- b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that child as a dependent of the parent with custody.
 - ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that child as a dependent of the parent without custody.

- iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

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

UTILIZATION REVIEW PROGRAM

Your Plan includes the process of utilization review to decide when services are Medically Necessary, Experimental, or Investigative as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care.

Certain services must be reviewed to determine medical necessity in order for you to get Benefits. Utilization review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a service that was asked for is not Medically Necessary if you have not tried other treatments that are more cost-effective.

If you have any questions about the information in this section, you may call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or go to the website at www.anthem.com/ca.

Coverage for or payment of the service or treatment reviewed is not guaranteed. For Benefits to be covered, on the date you get service:

1. You must be eligible for Benefits;
2. The service or supply must be a Covered Service under your Plan;
3. The service cannot be subject to an exclusion under your Plan (please see “Exclusions and Limitations” section for more information); and
4. You must not have exceeded any applicable limits under your Plan.

Anthem reviews an inpatient Hospital Stay for medical necessity after Medicare Benefits are exhausted. To initiate this review, call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). The Plan may also request to review other kinds of care for medical necessity.

You and your Physician will be advised if it is determined that the Stay is not Medically Necessary. If services are certified as not Medically Necessary, but you nevertheless choose to receive those services, you are responsible for all charges not reimbursed by the Plan.

If you have any questions concerning the decision regarding continuing care, you or your Physician may call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). If you do not agree with the determination, you or your Physician may appeal this decision by following the appeals process under the section entitled YOUR RIGHT TO APPEALS.

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

January 1, 2018

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.

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Complete Guide to Your UC Health Benefits.” A copy of this booklet is available in the HR Forms & Publications 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 & Publications 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.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the Plan is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with UC for details.

DEFINITIONS

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

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

Qualified Beneficiary means a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this Plan as either a Member or enrolled Spouse or Domestic Partner. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any Spouse or Domestic Partner acquired during the COBRA continuation period.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the Plan. The events will be referred to throughout this section by number.

1. **For Retired Employees and the Spouse or Domestic Partner.** Cancellation or a substantial reduction of retiree Benefits under the Plan due to the Plan's filing for Chapter 11 bankruptcy, provided that:
 - a. The Plan expressly includes coverage for retirees; and
 - b. Such cancellation or reduction of Benefits occurs within one year before or after the Plan's filing for bankruptcy.
2. **For Spouse or Domestic Partner:**
 - a. The death of the Member;
 - b. The Spouse's divorce or legal separation from the Member;
 - c. The end of a Domestic Partner's partnership with the Member;

ELIGIBILITY FOR COBRA CONTINUATION

A Member or enrolled Spouse or Domestic Partner may choose to continue coverage under the Plan if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. UC will notify either the Member or Spouse or Domestic Partner of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, UC will notify the Member of the right to continue coverage.
2. For Qualifying Events 2(b) or 2(c) above, a Spouse or Domestic Partner will be notified of the COBRA continuation right.
3. You must inform UC within 60 days of Qualifying Events 2(b) or 2(c) above, if you wish to continue coverage. UC, in turn, will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify UC within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for both Family Members, or for the Member only, or for the Spouse only.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A Spouse or Domestic Partner acquired during the COBRA continuation period is eligible to be enrolled, provided that the Spouse or Domestic Partner meets the eligibility requirements specified in ELIGIBILITY, ENROLLMENT AND TERMINATION PROVISIONS. The standard enrollment provisions of the Plan apply to enrollees during the COBRA continuation period.

Cost of Coverage. UC may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to UC each month during the COBRA continuation period in order to maintain the coverage in force.

Besides applying to the Member, the Member's rate will also apply to:

1. A Spouse whose COBRA continuation began due to divorce, separation or death of the Member;
2. A Domestic Partner whose COBRA continuation began due to the end of the domestic partnership or death of the Member;

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the required monthly contribution is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For Spouse or Domestic Partner properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the Plan.

When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

1. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the Member, divorce or legal separation, or the end of a domestic partnership;*
2. The date the Plan terminates;
3. The end of the period for which required monthly contributions are last paid;
6. The date, following the election of COBRA, the Member first becomes covered under any other group health plan.

*For a Member whose COBRA continuation coverage began under a Prior Plan, this term will be dated from the time of the Qualifying Event under that Prior Plan.

Subject to the Plan remaining in effect, a retired Member whose COBRA continuation coverage began due to Qualifying Event 1 may be covered for the remainder of his or her life; that person's covered Spouse or Domestic Partner may continue coverage for 36 months after the Member's death. However, coverage could terminate prior to such time for either Member or Dependent in accordance with any of the items above.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

GENERAL PROVISIONS

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

Independent Contractors. Anthem's relationship with Providers is that of an independent contractor. Physicians, and other health care professionals, Hospitals, Skilled Nursing Facilities and other community agencies are not Anthem's agents nor are they, or any of their employees, an employee or agent of any Hospital, medical group or medical care provider of any type.

Non-Regulation of Providers. The Benefits of this Plan do not regulate the amounts charged by Providers of medical care.

Inter-Plan Arrangements

Out-of-Area Services

Overview. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Blue Cross Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Blue Cross Service Area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") do not contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Blue Cross Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the *provider*. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem Blue Cross may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem Blue Cross by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem Blue Cross through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the group on your behalf, Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Non-Participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem Blue Cross's Service Area by non-Participating Providers, we may determine Benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as a Deductible or Copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-Participating Provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount we will pay for services provided by Non-Participating Providers. In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core ® Program

Benefits will also be provided for Emergency and non-Emergency Covered Services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you live or plan to travel outside the United States, call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to find out your Blue Cross Blue Shield Global Core Benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is **(800) 810-BLUE (2583)**. Or you can call them collect at **(804) 673-1177**.

If you need inpatient Hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest Hospital. There is no need to call before you receive care.

Please refer to the “Utilization Review Program” section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the Hospital for Emergency or non-Emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient Hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Physician Services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient Services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Terms of Coverage

1. In order for you to be entitled to Benefits under the Plan, both the Plan and your coverage under the Plan must be in effect on the date the expense giving rise to a claim for Benefits is Incurred.
2. The Benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for Benefits is Incurred. An expense is Incurred on the date you receive the service or supply for which the charge is made.
3. The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Protection of Coverage. UC does not have the right to cancel your coverage under this Plan while: (1) this Plan is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the Plan.

Medical Necessity. The Benefits of this Plan are provided only for services which Anthem determines to be Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this Plan is available to you upon request.

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

Benefits Not Transferable. Only the Member is entitled to receive Benefits under this Plan. The right to Benefits cannot be transferred.

Notice of Claim. You must send Anthem properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. UC is not liable for the Benefits of the Plan if you do not file claims within the required time period. UC will not be liable for Benefits if Anthem does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described, including the Tax ID and National Provider Identifier of the Provider(s) whom rendered each service. Claim forms must be used; canceled checks or receipts are not acceptable.

To obtain a claim form you or someone on your behalf may call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or go to the website at www.anthem.com/ca and download and print one.

Payment to Providers. The Benefits of this Plan will be paid directly to medical transportation providers. Also, other providers of service will be paid directly when you assign Benefits in writing. If another party pays for your medical care and you assign benefits in writing, the Benefits of this Plan will be paid to that party. These payments will fulfill the Plan's obligation to you for those Covered Services.

Exception: Under certain circumstances the Benefits of this Plan will be paid directly to a Provider or third party even without your assignment of benefits in writing. To receive direct payment, the Provider or third party must provide Anthem the following:

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

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

Under certain circumstances, if Anthem pays your healthcare Provider amounts that are your responsibility, such as Deductibles or Copayments, Anthem may collect such amounts directly from you. You agree that Anthem has the right to recover such amounts from you.

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

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

Plan Administrator - COBRA. In no event will Anthem be the Plan Administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "Plan Administrator" refers to Regents of The University of California or to a person or entity other than Anthem, engaged by to perform or assist in performing administrative tasks in connection with the Plan. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this Benefit Booklet, UC is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. UC may require that you contribute all or part of the costs of these required monthly contributions. Please consult UC for details.

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

Under the above-referenced contracts between Providers and Anthem or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Plan may differ from the rates paid for persons covered by other types of products or programs offered by Anthem or an affiliate for the same medical services. In negotiating the terms of the Plan, UC was aware that Anthem or its affiliates offer several types of products and programs. The Members and UC are entitled to receive the Benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the Plan.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem or an affiliate. They are not attributed to specific claims or plans and do not inure to the Benefit of any covered individual or group, but may be considered by Anthem or an affiliate in determining its fees or subscription charges or premiums.

Voluntary Clinical Quality Programs. Anthem may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. Anthem will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs. Anthem may offer health or fitness related program options for purchase by UC to help you achieve your best health. These programs are not Covered Services under your plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If UC has selected one of these options to make available to all Employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options UC may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) and Anthem will work with you (and, if you wish, your Physician) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

Program Incentives. UC may offer incentives from time to time at its discretion in order to introduce you to new programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making you aware of cost effective Benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. UC may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

Plan Notice of Privacy Practices for Anthem *

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. Anthem is required by HIPAA to notify you of the availability of its Notice of Privacy Practices. The notice describes the privacy practices, legal duties and your rights concerning your Protected Health Information. Anthem must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until Anthem publishes and issues a new notice).

Anthem may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: use and share PHI to manage your account or Benefits; or to pay claims for health care you get through your Plan.

For health care operations: use and share PHI for health care operations.

For treatment activities: does not provide treatment. This is the role of a health care provider, such as your doctor or a Hospital. Examples of ways Anthem use your information for payment, treatment and health care operations:

- keep information about your premium and Deductible payments.
- may give information to a doctor's office to confirm your Benefits.
- may share explanation of Benefits (EOB) with the Member of your Plan for payment purposes.
- may share PHI with your health care provider so that the provider may treat you.
- may use PHI to review the quality of care and services you get.
- may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit www.anthem.com/ca/health-insurance/about-us/privacy for more information.

Anthem, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related Benefits and services, enrollment, payment, or billing.

You may obtain a copy of the Notice of Privacy Practices at www.anthem.com/ca/health-insurance/about-us/privacy or you may contact Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

***Business Associate to the UC Medicare PPO without Prescription Drugs**

Notice of Privacy Practice for Plan

A copy of the University of California Healthcare Plan Notice of Privacy Practices - Self-Funded Plans (Notice) that applies to your Plan can be found at ucal.us/hipaa or you may obtain a paper copy of the UC Notice by calling the UC Healthcare Plan Privacy Office at 800-888-8267, press 1.

BINDING ARBITRATION

A dispute regarding a claim for Benefits, including prescription drug benefits administered as a Covered Service, must proceed first through the claims process described in YOUR RIGHT TO APPEALS section before any further legal action can be taken with respect to that claim. Otherwise any dispute or claim, of whatever nature, including a claim for Benefits that has completed the internal appeals process, that arises out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

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

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

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

The arbitration is begun by the Member making written demand on UC. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and UC, or by order of the court, if the Member and UC cannot agree that has completed the internal appeals process.

DEFINITIONS

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

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

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

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

Benefit Booklet is this written description of the Benefits provided under the Plan.

Benefit Period, as defined by Medicare for inpatient Hospital and Skilled Nursing Facility services (Part A), begins when you first enter a Hospital after your Medicare insurance begins. In no event will a new Benefit Period start until you have been discharged and have remained out of the Hospital or other facility as an inpatient for at least 60 consecutive days. For medical services (Part B), Benefit Period is defined as a Calendar Year.

Claims Administrator (Anthem) refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the Plan.

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

Covered Services are those Services which a Member is entitled to receive pursuant to the terms of the Plan document.

Creditable Coverage is any individual or group plan that provides medical, Hospital and surgical coverage, including continuation coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable Coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable Coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition. In addition, eligible children were covered under one of the above types of health coverage on his or her own and not as a Dependent child.

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

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

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

If Medically Necessary, Benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Day Treatment Center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of Mental Health Conditions or substance abuse under the supervision of Physicians.

Deductible is 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 Benefit payments from the Plan for those services. See page 15 under YOUR MEDICAL BENEFITS section.

Dependent as defined in the “Eligible Family Members” section of the “Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members”. A copy of this factsheet 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.

Domestic Partner as defined in the “Eligible Family Members” section of the “Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members”. A copy of this factsheet 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.

Effective Date is the date your coverage begins under this Plan.

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

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

Employee is an individual who meets the eligibility requirements established by the Employer and accepted by Anthem.

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

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

Family Member is the Member or an enrolled Dependent.

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

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

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care hospital

according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care, the definition of Hospital also includes: (1) Psychiatric Health Facilities (only for the acute phase of a Mental Health Conditions or substance abuse), and (2) Residential Treatment Centers.

Incurred a charge that will be considered to be “Incurred” on the date the particular services or supply which gives rise to it is provided or obtained.

Infertility is: (1) the presence of a condition recognized by a Physician as a cause of Infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or after 3 cycles of artificial insemination.

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a Mental Health Conditions or substance abuse, put the Members and others at risk of harm.

Intensive Outpatient Program is a short-term behavioral health treatment that provides a combination of individual, group and family therapy.

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

Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for covered medical services and supplies under this Plan. See YOUR MEDICAL BENEFITS – MAXIMUM ALLOWED AMOUNT.

Medically Necessary procedures, supplies equipment or services are those Anthem determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your Physician or another Provider;
6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient’s illness, injury, or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health Benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Medicare is Federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Medicare Benefits are those Benefits actually provided under Part A (Hospital Benefits) or Part B (medical Benefits) of Medicare to an individual having entitlement thereto, who made claim therefore, or the equivalent of those Benefits.

Medicare Eligible Expenses are expenses of the kinds covered by Medicare Part A and B to the extent recognized as reasonable and Medically Necessary by Medicare.

Member/Individual is the Employee, Spouse, or Dependent covered by the Plan.

Mental Health Conditions include conditions that constitute Severe Mental Disorders and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependence.

National Provider Identifier or NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

Non-Participating/Non-Preferred Providers are providers who have not contracted with Anthem to accept Anthem'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.

Other Health Care Provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A facility which provides diagnostic radiology services;
3. A blood bank;
4. A durable medical equipment outlet;
5. A clinical laboratory;
6. A Skilled Nursing Facility;
7. A Home Health Agency;
8. A licensed ambulance company;
9. A Hospice; or
10. An Ambulatory Surgical Center.

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

Other Providers is one of the following providers:

1. Independent Practitioners are licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dietitians; certified nurse mid-wives; licensed occupational therapists; certificated acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.
2. Healthcare Organizations such as 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.

Partial Hospitalization Program is a structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Participating Provider is a Physician or a Hospital that has contracted with Anthem to furnish Services and to accept the Anthem's payment, plus applicable Deductibles and Copayments, as payment in full for Covered Services.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following Providers, but only when the Provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which Benefits are specified in this booklet:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A licensed educational psychologist or other Provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.)
 - A licensed clinical social worker (L.C.S.W.)
 - A marriage and family therapist (M.F.T.)
 - A licensed professional clinical counselor (L.P.C.C.)*
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*
 - An audiologist*
 - An occupational therapist (O.T.R.)*
 - A respiratory care practitioner (R.C.P.)*
 - A nurse midwife**
 - A nurse practitioner
 - A Physician assistant
 - A Psychiatric Mental Health Nurse (R.N.)*
 - A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.
 - A qualified autism service Provider, qualified autism service professional, and a qualified autism service paraprofessional.

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

Plan is the University of California Supplement to Medicare for eligible Retired Employees and Dependents of the Employer.

Plan Administrator (UC) is The Regents of The University of California (UC).

Plan Sponsor is The Regents of the University of California.

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

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

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

Please call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) for additional information about services that are covered by this Plan as Preventive Care Services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

<http://www.healthcare.gov/what-are-my-preventive-care-benefits>

<http://www.ahrq.gov>

<http://www.cdc.gov/vaccines/acip/index.html>

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

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

Provider is a professional individual or facility licensed by law that gives health care services within the scope of that license and is approved by the Plan. Providers that deliver Covered Services are described throughout this Benefit Booklet. If you have a question about a Provider not described in this Plan, please call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

Psychiatric Emergency Medical Condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

Psychiatric Health Facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to the California Insurance Code;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a Physician as medical director.

Psychiatric Mental Health Nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reconstructive Surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

Residential Treatment Center is a Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more doctors available at all times;
- Residential treatment that takes place in a structured facility-based setting;
- The resources and programming to adequately diagnose, care and treat a Mental Health Conditions or substance abuse;
- Facilities that are designated for residential, sub-acute, or intermediate care and that may occur in care systems that provide multiple levels of care; and
- Accreditation by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic is a facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores.

Retired Employee as defined in the “Eligible Family Members” section of the “Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members”. A copy of this factsheet 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.

Services include medical necessary healthcare services and Medically Necessary supplies furnished incident of those services.

Severe Mental Disorders include severe mental illness as specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Education Code Section 56320).

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

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse as defined in the “Eligible Family Members” section of the “Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members”. A copy of this factsheet 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.

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

Totally Disabled Dependent is a Dependent who is unable to perform all activities usual for persons of that age.

Totally Disabled Member is a Member who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which they become qualified by training or experience, and who are in fact unemployed.

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

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

To find an Urgent Care Center, please call Anthem Health Guide number toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or you can also search online using the “Find a Doctor” function on the website at www.anthem.com/ca. Please call the Urgent Care Center directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to Anthem.

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

You (your) refers to the Member and Dependents who are enrolled for Benefits under this Plan.

YOUR RIGHT TO APPEALS

Medicare Denied Claims.

This Plan supplements the benefits paid by Medicare. If a medical claim has been denied by Medicare, the supplemental payment through this Plan will also be denied, as secondary payment by this Plan is dependent upon Medicare's primary payment. You must appeal the Medicare determination with Medicare if the Medicare claim is denied.

Claim Denials for Benefits and Coverages Not Covered by Medicare

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure Anthem will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, Anthem's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Anthem's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or Experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- Anthem's notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Anthem's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- Anthem shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for Anthem to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact Anthem at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. Urgent Care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include Your Member Identification Number when submitting an appeal.

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the *plan's* policy or guidance about the treatment or *benefit* relative to your diagnosis.

Anthem will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, Anthem will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When Anthem considers your appeal, it will not rely upon the initial Benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, Anthem will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, Anthem will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, Anthem will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied, that denial will be considered an adverse Benefit determination. The notification from Anthem will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Anthem's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of Benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other Benefits under this health care Plan. There is no charge for you to initiate an independent External Review.

Requirement to file an Appeal before taking further legal action

No lawsuit or legal action of any kind related to a Benefit decision may be filed by you in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or Benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before taking other legal action of any kind against the Plan.

Anthem reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

FOR YOUR INFORMATION

Anthem Blue Cross Web Site

Information specific to your Benefits and claims history are available by calling Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross's web site to access Benefit information, claims payment status, Benefit maximum status, Participating Provider or to order an ID card. Simply log on to www.anthem.com/ca, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site.

Identity Protection Services

Anthem has made identity protection services available to Members. To learn more about these services, please visit www.anthem.com/resources.

Language Assistance Program

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact Anthem Health Guide by calling toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross Life and Health also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711**.

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or Other Health Care Provider obtain authorization for prescribing a length of Stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

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

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call Anthem Health Guide toll-free at **(844) 437-0486**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

Language Assistance Services for Self-Funded PPO Plans

English: Language assistance services, free of charge, are available to you. Call 1-877-437-0486 TTY Users Call 711.

Arabic: 711 ب ات صل تي 1-877-437-0486 ب الرقم ات صل مجاناً لك م تاحة ال لغوية الامساعدة خدمات

Armenian: Լեզվի օգնության ծառայությունները մատչելի են ձեզ համար անվճար: Ձանգահարեք 1-877-437-0486 TTY Users զանգահարեք 711:

Farsi: ب گ یرید تماس 1-877-437-0486 TTY ت ل فن شماره ب ا است رایگان شما ب رای زبان به مک خدمات 711.

Hindi: भाषा सहायता सेवाएं आपके लिए निः शुल्क उपलब्ध हैं कॉल 1-877-437-0486 टीटीआई उपयोगकर्ता कॉल 711

Hmong: Cov kev pabcuam hauv kev txhais lus muaj rau koj dawb xwb. Hu rau 1-877-437-0486 TTY Cov Neeg Siv Hu Xov tooj 711.

Japanese: 言語支援サービスは無料でご利用いただけます。電話1-877-437-0486 TTYユーザーは711に電話をかける。

Khmer: សេវាកម្មជំនួយភាសាអាចរកបានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-877-437-0486 អ្នកប្រើ TTY ហៅលេខ 711 ។

Korean: 언어 지원 서비스는 무료로 이용하실 수 있습니다. 전화 1-877-437-0486 TTY 사용자는 711에 전화하십시오.

Punjabi: ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ. ਕਾਲ ਕਰੋ 1-877-437-0486 TTY ਉਪਭੋਗਤਾ ਕਾਲ 711.

Russian: Языковые услуги предоставляются вам бесплатно. Вызов 1-877-437-0486 Пользователи TTY Вызов 711.

Spanish: Los servicios de asistencia lingüística están disponibles gratuitamente. Llame al 1-877-437-0486 Usuarios de TTY Llame al 711.

Tagalog: Ang mga serbisyo ng tulong sa wika ay libre sa iyo. Tumawag sa 1-877-437-0486 Mga gumagamit ng TTY Tumawag sa 711.

Thai: มีบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย โทร 1-877-437-0486 ผู้ใช้ TTY โทร. 711

Chinese: 免费提供语言援助服务。致电1-877-437-0486 TTY用户致电711。

Vietnamese: Các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gọi số 1-877-437-0486 Người sử dụng TTY Gọi số 711.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law. UC's Self-Funded Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The UC Self-Funded Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UC's Self-Funded Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact 1-877-437-0486 (TTY 711).

If you believe that UC's Self-Funded Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: UC's Lead Discrimination Affirmative Action Title IX Officer, 1111 Franklin St., 5th Floor, Oakland, CA 94607, Phone Number: (510) 987-0104, Fax Number: (510) 217-9114, Email: Katya.Nottie@ucop.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, UC's Lead Discrimination, Affirmative Action Title IX Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY