Anthem Blue Cross

UNIVERSITY OF CALIFORNIA

January 1, 2011

Anthem Lumenos®
PPO with HRA Plan

PPO Benefits

CERTIFICATE OF INSURANCE

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

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

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

TABLE OF CONTENTS

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PPO with HRA for
University of California

BENEFITS AT A GLANCE

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

This Lumenos plan includes a health reimbursement account in which the member's employer places money in the HRA for the members to use on routine medical care. The plan also includes traditional health coverage that protects the member against large medical expenses. Covered expenses are paid for by the HRA account with no copays or deductibles to satisfy. If covered expenses exceed the member's available HRA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by member. Certain Covered Services have maximum visit and/or day limits per year. Members are responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense. Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

Participating Providers—Negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-Participating Providers & Other Health Care Providers *(includes those not represented in the PPO provider network)*—the customary & reasonable charge for professional services or the reasonable charge for institutional services.

Participating Pharmacies & Mail Service Program—Prescription drug negotiated rates. Members are not responsible for any amount in excess of the prescription drug negotiated rate.

Non-Participating Pharmacies—Drug limited fee schedule amount. Members are responsible for any expense not covered under this plan & any amount in excess of drug limited fee schedule amount.

Penalty--- Penalty for not obtaining preauthorization when required. $500/occurrence, Applies to Non-PPO inpatient services & selected Non-PPO outpatient surgeries & diagnostic tests

When using non-participating providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

When using the outpatient prescription drug benefits, members are always responsible for drug expense which is not covered under this plan, as well as any deductible, percentage or dollar copay.

HRA Allocation *[allocation provided by the employer]* *(covered expenses incurred are paid from this allocation until HRA dollars are exhausted; applied toward calendar year deductible & out-of-pocket maximums; unused HRA dollars roll over year-to-year)* *HRA eligible Expenses (covered eligible medical/prescription expenses month (includes behavioral health)*	$1,000/individual member $1,500/individual & adult $1,500/individual & children $2,000/insured/family *Note: The HRA Allocation may be prorated based on the the member joins the plan (1/12th for each month in the plan)*
Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual member	$1,700
➢ Individual & Adult	$2,550
➢ Individual & Children	$2,550
➢ Insured family (collective deductible-one family member may satisfy entire deductible)	$3,400 *Note:* Deductible cross-accumulate between PPO and Non-PPO.

Annual Out-of-Pocket Maximums *(in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense)*	
➢ Participating Providers, Participating Pharmacy & Other Health Care Providers	$5,000/individual member $7,500/individual & adult; $7,500/individual & children; $10,000/insured family/year
➢ Non-Participating Providers & Non-Participating Pharmacy	$10,000/individual member $15,000/individual & adult $15,000/individual & children $20,000/insured family/year

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense. After an individual member or insured family *(includes subscriber & one or more members of the subscriber's family*) reaches the out-of-pocket maximum for all medical and prescription drug covered expense the individual member or insured family incurs during that calendar year, the individual member or insured family will no longer be required to pay a copay for the remainder of that year. The individual member or insured family remains responsible for costs in excess of the covered expense when provided by non-participating providers and other health care providers; non-covered expense.

Lifetime Maximum	Unlimited	
Covered Services	Traditional Health Coverage Member Copay	
	In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	40%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	40%
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%	40%
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 180 days/calendar year)*	20%	40%
Hospice Care		
➢ Inpatient or outpatient services for members; family bereavement services	20%	40%
Home Health Care		
➢ Services & supplies from a home health agency *(limited to 180 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	40%
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	40%
Physician Medical Services		
➢ Office & home visits	20%	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(excluding x-ray & lab services performed for a routine exam)*	20%	40%
➢ Other diagnostic x-ray & lab	20%	40%

Covered Services	Traditional Health Coverage Member Copay	
	In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Preventive Care Services *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*		
➢ Routine physical examinations *(birth through age six)*	No copay *(deductible waived)*	40%
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	40%
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay *(deductible waived)*	40%
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	40%
Outpatient Private Duty Nursing (*preauthorization required; limited to180/calendar year)*	20%	40%
Physical Therapy, Physical Medicine, Occupational Therapy & Chiropractic Care	20%	40%
➢ Physical Therapy, Physical Medicine & Occupational Therapy *(limited to 90 visits/calendar year combined with Speech Therapy)*	*20%*	*40%*
➢ Chiropractic Care *(limited to 20 visits/calendar year combined with Acupuncture)*	*20%*	*40%*
Speech Therapy Outpatient speech therapy following injury or organic disease (limited to 90 visits/calendar year combined with Physical therapy physical medicine & occupational therapy)	20%	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year combined with Chiropractic Care)*	20%[1]	40%[1]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	20%	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	20%	40%
Organ & Tissue Transplants *(subject to utilization review;specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	No charge at CME / 20% Non CME center	
➢ Transplant travel expense for an authorized, specified transplant at a CME *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days). 2 transplant procedures for the same condition per person.*	No charge at CME (up to $10,000 per transplant); not covered at Non CME center	

[1] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	Traditional Health Coverage Member Copay	
	In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric CME *(member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	20%	
Transgender Surgery* *(deductible applies)*		
➢ Inpatient hospital services	20%	Not covered
➢ Physician office visits, including specialists	20%	Not covered
➢ Surgeon, assistant surgeon	20%	Not covered
➢ Anesthetist	20%	Not covered
➢ Skilled nursing facility *(preauthorization required)* Limited to 240 days/calendar year	20%	Not covered
➢ Rehabilitative care	20%	Not covered
**Benefits provided through authorized Transgender Surgery physicians only.*		
➢ Transgender Surgery travel expense (*deductible waived*) Transportation limited to 6 trips/episode & $250/person/trip for round trip, coach fare, hotel limited to1 room double occupancy, $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip.	No copay	Not covered
➢ Transgender Surgery Lifetime Maximum: $75,000		
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit available for one hearing aid per ear every three years)*	20%	40%

[1] These providers are not represented in the PPO network.

[2] 20% if member or non-PPO physician obtains drug from Specialty Drug Program; otherwise, not covered.

Covered Services	Traditional Health Coverage Member Copay	
	In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	
Specialty Drugs *(utilization review may be required)*		
➢ Specialty drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	20%	Not covered[2]
If member does not get specialty drugs from the Specialty Drug Program, member will not receive any Specialty Drug Program benefits under this plan, unless the member qualifies for an exception as specified in the Certificate.		
Emergency Care		
➢ Emergency room services & supplies	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%
➢ Urgent Care (freestanding)	20%	20%
Outpatient Prescription Drug Benefits		
➢ Retail pharmacy prescription drug maximum allowed amount	20%	40%[1]
➢ Mail service prescription drug maximum allowed amount	20%	Not applicable
➢ Specialty drugs *(obtained through specialty drug program)*	20%	Not applicable
Supply Limits[2]		
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
➢ Mail Service	90-day supply	
➢ Specialty Drug Program	30-day supply	

1 Member remains responsible for the costs in excess of the prescription drug maximum amount allowed.

2 Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information.

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2011

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

ELIGIBILITY

Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan. Employees enrolled in this plan at time of retirement who are eligible to continue UC medical coverage will be able to continue enrollment in this Plan into retirement until the Retiree or the Retiree's family member becomes eligible for Medicare. See "Effect of Medicare on Enrollment" below. Once Medicare eligibility is attained by a Retiree or any Family Member, the Retiree is required to change to another University medical plan.

The following individuals are eligible to enroll in this Plan.

Subscribers

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

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

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

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan provided that you also meet the following requirements:

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

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

(c) you elect to continue (or effective 1/1/05 suspend) medical coverage at the time of retirement.

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

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

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), domestic partner verification, adoption records, Federal Income Tax Return, or other official documentation.

Eligible Adults:

Spouse: Your legal spouse.

Same Sex-Domestic Partner: You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations.

Opposite-Sex Domestic Partner: The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

Note: An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 and continues to be ineligible for Medicare Part A may continue coverage in UC-sponsored plans.

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

(a) your natural or legally adopted children;

(b) your spouse's natural or legally adopted children (your stepchildren);

(c) your eligible domestic partner's natural or legally adopted children;

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

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

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

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;

- the child is chiefly dependent upon you. your spouse, or your eligible domestic partner for support and maintenance, is unmarried; and
- the child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security Income or Supplemental Security Income as a disabled person, or working in supported employment which may offset the Social Security or Supplemental Security Income.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

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

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). UC dependent eligibility requirements may change following final health care reform legislation, regulatory guidance, or other applicable laws.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

ENROLLMENT

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

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day when enrolling with forms.

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

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

(a) For a spouse, on the date of marriage.

(b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

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

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

(i) the date the child is placed for adoption with the Employee/Retiree, or

(ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

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

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

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

If you are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the service area.

At Other Times for Employees and Retirees

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

90-Day Waiting Period. If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

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

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

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

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

1. You have met all of the following requirements:

    a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).

    b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.

    c. Your coverage under the other health plan wherein you or your eligible Family Members were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or CalCOBRA continuation was exhausted, or you lost coverage under CHIP or Medicaid because you were no longer eligible for those programs.

    d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2. You or your eligible Family Members are not currently enrolled and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

3. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within the PIE which begins the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)

4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

    a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

    b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time.

Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

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

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring, and you may change your plan during the University's next open enrollment period. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin). Retirement alone does not grant a PIE to enroll or change your medical plan.

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

Effective Date

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

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

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

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

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

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

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage

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

Effect of Medicare on Enrollment

As an Employee, if you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in

both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment.

As a Retiree, if you and your covered Family Member(s) become eligible for premium-free Medicare Part A then you and your covered Family Member must also enroll, and remain, in Medicare Part B or you will permanently lose your UC-sponsored medical coverage.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in Part A and Part B of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment. **Once Medicare coverage is established, you and any eligible family members are no longer eligible to participate in this plan. You should contact UC Customer Service and transfer to another UC medical plan for which you are eligible.**

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire. Continued employment past age 65 may delay enrollment into Part B, however, once enrolled, Part B must be continuous.

TERMINATION OF COVERAGE

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

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

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

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

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to

Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

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

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

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act,, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Grace Period

There shall be a Grace Period which provides additional time for UC to complete full payment of monthly premiums to Plan following the premium Due Date. The Due Date is the date the full premium is due and payable to Plan for a coverage month. The Grace Period shall be in force 31 days following the Due Date. The Agreement shall remain in force during the Grace Period. No penalties or late fees shall be charged by the insurance carrier to UC during the Grace Period. If UC fails to pay the insurance carrier the premiums due during the Grace Period, the carrier will not end coverage for covered Employee Members or Family Members until the end of the Grace Period. The Employee Members will not be required by the carrier to pay the premiums for UC nor will Members be required to pay more than their copay for any services received during the Grace Period.

If premiums due are not paid by the end of the Grace Period, the Agreement will be canceled as described above. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

PLAN ADMINISTRATION

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

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

Sponsorship and Administration of the Plan. The University of California is the Plan sponsor and plan administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California

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

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by Anthem Blue Cross Life and Health Insurance Company. If you have a question about benefits under the Plan or about a specific claim, please contact Anthem Blue Cross Life and Health Insurance Company at the following address and phone number:

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

Anthem Blue Cross Life and Health's Customer Service number is (888) 209-7975

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

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

Plan Year. The plan year is January 1 through December 31.

Continuation of the Plan. The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements. The benefits under the Plan are provided by Anthem Blue Cross Life and Health Insurance Company under a Group Service Agreement.

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

Agent for Serving of Legal Process. Legal process may be served on Anthem Blue Cross Life and Health Insurance Company at the address listed above.

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

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

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

Claims under the Plan. To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

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

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

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

We publish a directory of Participating Providers. You can get a directory from your plan administrator (usually your employer) or from us. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at **www.anthem.com/ca**. The listings include the credentials of our *participating providers* such as specialty designations and board certification.

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

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

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

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Member's Rights and Responsibilities. Anthem Blue Cross Life and Health Insurance Company is committed to maintaining a mutually respectful relationship with our *members*, and at the same time we expect our *members* to assume certain responsibilities. Your Member's Rights and Responsibilities are described below. Your rights, our legal duties, and our privacy practices related

to HIPAA are described in our "Notice of Privacy Practices" found on our website at www.anthem.com/ca/uc or by calling the customer service telephone number on your ID card.

Anthem Blue Cross Life and Health Insurance Company is committed to:

- Recognizing and respecting you as a member;
- Encouraging your open discussions with your health care professionals and providers;
- Providing information to help you become an informed health care consumer;
- Providing access to health benefits and our network providers;
- Sharing our expectations of you as a member.

Member's Rights. You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care;
- Receive the benefits for which you have coverage;
- Be treated with respect and dignity;
- Privacy of your personal health information, consistent with state and federal laws, and our policies;
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities;
- Candidly discuss with your *physicians* and providers appropriate or *medically necessary* care for your condition, regardless of cost or benefit coverage;
- Make recommendations regarding the organization's *member's* rights and responsibilities policies;
- Voice complaints or appeals about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided;
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your *physician(s)* of the medical consequences;
- Participate in matters of the organization's policy and operations.

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

- Choose a participating primary care *physician* if required by your health benefit plan;
- Treat all health care professionals and staff with courtesy and respect;
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation;
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it;
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible;

- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care;
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider;
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you;
- Follow all health benefit plan guidelines, provisions, policies and procedures;
- Let our Customer Service Department know if you have any changes to your name, address, or *family members* covered under your policy;
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our *members*. Benefits and coverage for services provided under the benefit program are governed by the entire Certificate of Insurance and the Group Policy and not by this Member's Rights and Responsibilities statement.

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the *prescription drug maximum allowed amount* to fill the *prescription*. After you have met your Calendar Year Deductible, you pay only your co-payment amount.

"Non-Participating Pharmacies" have not agreed to the *prescription drug maximum allowed amount*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

Centers of Medical Excellence. We are providing access to the following separate *Centers of Medical Excellence* (CME) networks. The facilities included in each of these *CME* networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, *CME* agree to accept the *negotiated rate* as payment in full for covered services.
- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a *CME*.**

A *participating provider* in the Prudent Buyer Plan network is not necessarily a *CME* facility

SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH ARE DETERMINED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE.

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

The benefits provided in this certificate are subject to applicable federal and California laws. There are some states that require more generous benefits be provided to their residents even if the master policy was not issued in their state. If your state has such requirements, we will adjust your benefits to meet the minimum requirements.

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

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

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

IMPORTANT INFORMATION ABOUT YOUR MEDICAL BENEFITS

UTILIZATION REVIEW PROGRAM REQUIREMENTS -- Your *plan* has UTILIZATION REVIEW PROGRAM requirements. These are explained in the UTILIZATION REVIEW PROGRAM section beginning on page 69. **Your benefits may be reduced** if you do not follow the procedures outlined. If you have any questions about the UTILIZATION REVIEW PROGRAM requirements, call us at the toll-free number on your identification card.

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

For an *emergency* admission or procedure, we must be notified within one working day of the admission or procedure. Failure to notify us of such care may result in your benefits being denied or reduced. Please refer to the section entitled UTILIZATION REVIEW PROGRAM, beginning on page 69, for details.

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

DISPUTES/APPEALS -- The Agent for Service of Legal Process is Anthem Blue Cross Life and Health Insurance Company. Provisions describing the process for member disputes, complaints, and requests for review of denied claims can be found under the sections "INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT", "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE" and "BINDING ARBITRATION". See pages 85-88 for details.

HEALTH INCENTIVE ALLOCATION

Before the Calendar Year Deductible is satisfied, benefits of this *plan* are paid at **100%** of the *covered expense* incurred, up to the following allocation amounts:

- Subscriber without Family Members Health Incentive Allocation.....**$1,000** per *calendar year*
- Subscriber with One Adult Family Member Health Incentive Allocation.....**$1,500** per *calendar year*
- Subscriber & Children Health Incentive Allocation.....**$1,500** per *calendar year*
- Family Health Incentive Allocation.....**$2,000** per *calendar year*

You are not required to pay any Calendar Year Deductible for these benefits. *Covered expense* incurred will be applied toward your Calendar Year Deductible and Out-of-Pocket Amount.

Note: If your effective date under this *plan* is anytime after the effective date of this *plan*, the amount of your Health Incentive Allocation will be prorated based on the month of your effective date, as specified under HEALTH INCENTIVE ALLOCATION.

MEDICAL AND PRESCRIPTION DRUG BENEFITS

DEDUCTIBLES

Calendar Year Deductibles Applicable to Medical and Prescription Drug Benefits

- Subscriber without Family Members Deductible **$1,700**
- Subscriber with One Adult Family Member Deductible **$2,550**
- Subscriber & Children Deductible **$2,550**
- Family Deductible **$3,400**

Exceptions: In certain circumstances, the Calendar Year Deductibles may not apply, as described below:

– The Calendar Year Deductible will not apply to the following services provided by a *participating provider*: (a) *physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; and (b) the Physical Exam benefit.

– The Calendar Year Deductible will not apply to benefits for services provided by a *participating provider* for screening for blood lead levels in children at risk for lead poisoning.

– The Calendar Year Deductible will not apply to services provided by *participating providers* under the Adult Preventive Services benefit.

- **Non-Certification Deductible** ..... **$ 500**

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

CO-PAYMENTS APPLICABLE TO MEDICAL AND PRESCRIPTION DRUG BENEFITS

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

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

Note: In addition to the Co-Payment shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.

***Exceptions:**

– You will not be required to pay a Co-Payment for a routine examination or immunizations provided by a *participating provider* under the Well Baby and Well Child Care benefit.

– You will not be required to pay a Co-Payment for services provided by a *participating provider* for screening for blood lead levels in children at risk for lead poisoning.

– You will not be required to pay a Co-Payment for services provided by a *participating provider* under the Physical Exam benefit and the Adult Preventive Services benefit.

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

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

  a. All *emergency services;*

  b. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;

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

  d. Cancer Clinical Trials.

- You are not required to make a Co-Payment for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated *CME*. See UTILIZATION REVIEW PROGRAM.

  NOTE: No Co-Payment will be required for the transplant travel expenses authorized by us in connection with a specified transplant performed at a designated *CME*. Transplant travel expense coverage is available when the closest *CME* is 250 miles or more from the recipient's or donor's residence.

- Your Co-Payment for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* but that are not performed at a designated *CME* will be 20%. See UTILIZATION REVIEW PROGRAM.

- Your Co-Payment for bariatric surgical procedures determined to be *medically necessary* and performed at a designated *CME* will be the same as for *participating providers*. **Services for bariatric surgical procedures are not covered when performed at other than a designated *CME*.** See UTILIZATION REVIEW PROGRAM.

  NOTE: Co-Payments do not apply to bariatric travel expenses authorized by us. Bariatric travel expense coverage is available when the closest *CME* is 50 miles or more from the *member's* residence.

Prescription Drug Co-Payments. The following co-payments apply for each *prescription* after you have met your Medical and Prescription Drug Calendar Year Deductible:

Retail Pharmacies - For a 30-day supply of medication

- **Participating Pharmacies**..... **20%**
  of *prescription drug covered expense*

Please note that presentation of a *prescription* to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, your deductible, if any, needs to be satisfied, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager*.

- **Non-Participating Pharmacies***..... **40%**
  of *prescription drug covered expense*

Note: Unless an exception is made, after the first two-month supply of a *specialty drug* is obtained through a retail pharmacy, the drug is available only through the Specialty Drug Program, see Specialty drug Prescriptions below.

- **Mail Order Prescriptions –** For a 90-day supply of medication..... **20%** of *prescription drug covered expense*

Note: *Specialty drugs* are not available through the mail service program, see Specialty Drug Prescriptions below.

- **Specialty Drug Prescriptions –** For a 30-day supply of medication obtained from the Specialty Drug Program..... **20%** of *prescription drug covered expense*

***Important Note About Prescription Drug Covered Expense and Your Co-Payment:** *Prescription drug covered expense* for *non-participating pharmacies* is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a *non-participating pharmacy*.

YOU WILL BE REQUIRED TO PAY YOUR CO-PAYMENT AMOUNT TO THE PARTICIPATING PHARMACY AT THE TIME YOUR PRESCRIPTION IS FILLED.

MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNT

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

Subscriber without Family Members

- *Participating provider, other health care provider, participating pharmacy,* and prescription mail service **$5,000**
- *Non-participating provider* and *non-participating pharmacy*.....**$10,000**

Subscriber with One Adult Family Member

- *Participating provider, other health care provider, participating pharmacy,* and prescription mail service **$7,500**
- *Non-participating provider* and *non-participating pharmacy*.....**$15,000**

Subscriber with Children

- *Participating provider, other health care provider, participating pharmacy,* and prescription mail service **$7,500**
- *Non-participating provider* and *non-participating pharmacy*.....**$15,000**

Per Family

- *Participating provider, other health care provider, participating pharmacy*, and prescription mail service **$10,000**
- *Non-participating provider* and *non-participating pharmacy*.....**$20,000**

Exception: Expense which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense,* will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

- For covered *skilled nursing facility* care ..... **180 days** per *calendar year*

Home Health Care

- For covered home health services ..... **180 visits** per *calendar year*

Outpatient Private Duty Nursing

- For covered private duty nursing services ..... **180 days** per *calendar year*

Outpatient Speech Therapy

- For covered services ..... **90 visits** per *calendar year* *(*combined with physical therapy, physical medicine and occupational therapy)

Physical Therapy, Physical Medicine, Occupational Therapy & Chiropractic Care

- Physical therapy, physical medicine & occupational therapy ..... **90 visits** per *calendar year* (combined with speech therapy)
- Chiropractic care services ..... **20 visits** per *calendar year* (combined with acupuncture care)

Acupuncture

- For all covered services ..... **20 visits** per *calendar year* (combined with chiropractic care)

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
  - For transportation to the *CME* ..... **$250** per trip for each person for round trip coach airfare
  - For hotel accommodations ..... **$100** per day, for up to 21 days per trip, limited to one room, double occupancy
  - For other reasonable expenses (excluding meals, tobacco, alcohol and drug expenses) ..... up to **$25** per day, per person, for up to 21 days per trip

- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the *CME* .....**$250** for round trip coach airfare
  - For hotel accommodations .....**$100** per day, for up to 7 days
  - For other reasonable expenses (excluding meals, tobacco, alcohol and drug expenses) .....up to **$25** per day, for up to 7 days
- Maximum per Transplant, not to exceed **$10,000**

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
  - For transportation to the *CME* ..... up to **$130** per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
  - For transportation to the *CME* ..... up to **$130** per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)

  Hotel accommodations ..... up to **$100** per day, for up to 2 days per trip, limited to one room, double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)

  Hotel accommodations ..... up to **$100** per day, for up to 4 days, limited to one room, double occupancy
- For other reasonable expenses (excluding meals, tobacco, alcohol and drug expenses) .....up to **$25** per day, for up to **4** days per trip

Hearing Aid Services

- For covered charges for hearing aids .....One hearing aid per ear every three years

Lifetime Maximum

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

TRANSGENDER SURGERY BENEFITS

CALENDAR YEAR DEDUCTIBLES*

- Subscriber without Family Members Deductible **$1,700**
- Subscriber with One Adult Family Member Deductible **$2,550**
- Subscriber & Children Deductible **$2,550**
- Family Deductible **$3,400**

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

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

CO-PAYMENTS

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

Hospital Services

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

Skilled Nursing Facility Services

- Skilled nursing care **20%**

Physician

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

MAXIMUMS

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

Skilled Nursing Facility

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

Transgender Surgery Travel Expense

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

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

HEALTH INCENTIVE ALLOCATION

Under Health Incentive Allocation, we pay all of the *covered expense* you incur up to the Health Incentive Allocation shown in the SUMMARY OF BENEFITS before you have to satisfy the Calendar Year Deductible.

Individual Health Incentive Allocation. If only the *subscriber* is covered under this *plan*, each *year* the *subscriber* will have benefits for *covered expense* incurred under this *plan* up to the Subscriber Health Incentive Allocation.

Family Health Incentive Allocation.

- If the *subscriber* without *family members* is covered under this *plan*, each *year* the *subscriber* will have benefits for *covered expense* incurred under this *plan* up to the Health Incentive Allocation of **$1,000**. Once the *subscriber* uses all of the Health Incentive Allocation in a *year*, no more Health Incentive Allocation will be available for the remainder of that *year*.

- If the *subscriber* and one adult *family member* are covered under this *plan*, each *year* the *subscriber* and *family member* will have benefits for *covered expense* incurred under this *plan* up to the Health Incentive Allocation of **$1,500**. Once the *subscriber* and/or *family member* use all of the Health Incentive Allocation in a *year*, no more Health Incentive Allocation will be available for the remainder of that *year*.

- If the *subscriber* and his or her children who are covered under this *plan* as *family members*, each *year* the *subscriber* and *family members* will have benefits for *covered expense* incurred under this *plan* up to the Health Incentive Allocation of **$1,500**. Once the *subscriber* and/or *family members* use all of the Health Incentive Allocation in a *year*, no more Health Incentive Allocation will be available for the remainder of that *year*.

- If the *subscriber* and three or more family members are covered under this *plan*, each *year* the *subscriber* and *family members* will have benefits for *covered expense* incurred under this *plan* up to the Family Health Incentive Allocation of **$2,000**. Once the *subscriber* and/or *family member* use all of the Family Health Incentive Allocation in a *year*, no more Health Incentive Allocation will be available for the remainder of that *year*.

Covered expense will be applied toward your Calendar Year Deductible and Out-of-Pocket Amount.

Claims submitted for covered services under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED will be processed at 100% of *covered expense* up to the Health Incentive Allocation. We will record your Health Incentive Allocation expense in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply.

Note: If your effective date under this *plan* is anytime after the effective of this *plan*, the amount of your Health Incentive Allocation will be prorated based on the month of your effective date. For example, if your coverage is effective in 11th month of the *calendar year*, you will receive 2/12ths of the allocation specified in the SUMMARY OF BENEFITS for the two months of the *calendar year* you are covered under the *plan* and you will receive the full allocation specified in the SUMMARY OF BENEFITS at the start of the next *calendar year.* If you are covered as a subscriber and you add coverage for your *family members* after the effective date of this *plan*, the Family Health Incentive Allocation will be prorated based on the month of effective date for family coverage. You and your family will receive the full allocation specified in the SUMMARY OF BENEFITS at the start of the next *calendar year*.

MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLES

CALENDAR YEAR DEDUCTIBLES

Subscriber Deductible (For a Subscriber without Family Members). The *member* must pay deductible expense in a *year* equal to the Subscriber Deductible before medical benefits are paid.

Subscriber with One Adult Family Member Deductible. *Members* of an enrolled family must pay deductible expense in a *year* equal to the Subscriber with One Adult Family Member Deductible before medical benefits are paid. No benefit payments will be made for any *member* until the Subscriber with One Adult Family Member Deductible is met. Once the Subscriber with One Adult Family Member Deductible is satisfied, benefits will be paid and no further Calendar Year Deductible expense will be required for any *member*.

Subscriber with Children Deductible. *Members* of an enrolled family must pay deductible expense in a *year* equal to the Subscriber with Children Deductible before medical benefits are paid. No benefit payments will be made for any *member* until the Subscriber with Children Deductible is met. Once the Subscriber with Children Deductible is satisfied, benefits will be paid and no further Calendar Year Deductible expense will be required for any *member*.

Family Deductible (For a Subscriber with Spouse, or Domestic Partner, and Children). *Members* of an enrolled family must pay deductible expense in a *year* equal to the Family Deductible before medical benefits are paid. No benefit payments will be made for any *member* until the Family Deductible is met. Once the Family Deductible is satisfied, benefits will be paid and no further Benefit Year Deductible expense will be required for any *member*.

Prior Plan Calendar Year Deductibles. If you were covered under the *prior plan* any amount paid during the same calendar year toward your calendar year deductible under the *prior plan,* will be applied toward your Calendar Year Deductible under this *plan*; provided that, such payments were for charges that would be covered expense under this *plan*.

NON-CERTIFICATION DEDUCTIBLE

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

MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

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

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

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

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The charges which are not considered *covered expense* will not be applied toward satisfaction of an Out-of-Pocket Amount.

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

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

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

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

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

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

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

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

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

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

CO-PAYMENTS AND MEDICAL BENEFIT MAXIMUMS

After you satisfy your Medical and Prescription Drug Deductible, we will subtract your Co-Payment and we will pay benefits up to the amount of *covered expense,* not to exceed the applicable Medical Benefit Maximum. The Co-Payments and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CO-PAYMENTS

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

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

MEDICAL BENEFIT MAXIMUMS

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

Prior Plan Maximum Benefits. If you were covered under the *prior plan,* any benefits paid to you under the *prior plan* will reduce any maximum amounts you are eligible for under this *plan* which apply to the same benefit.

CONDITIONS OF COVERAGE

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

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

MEDICAL CARE THAT IS COVERED

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

Hospital

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

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 180 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

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

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

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

In no event will benefits exceed 180 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

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

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.

8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *insured family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

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

1. Medication(*specialty drugs* must be obtained through the Specialty Drug Program (see the "Specialty Drugs," provision of this section MEDICAL CARE THAT IS COVERED), ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications(if outpatient prescription drug benefits are provided under this *plan*, *compound medications* must be obtained from a *participating pharmacy*);

3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

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

Professional Services

1. Services of a *physician*.

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

Outpatient Private Duty Nursing. We will pay for up to 180 days each *calendar year* for private duty nursing services of a licensed nurse (R.N., L.P.N. or L.V.N.) for care of a non-hospitalized acute illness or injury, provided your *physician* orders, and we authorize, the services as *medically necessary*.

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

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

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes *medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Ambulance. The following ambulance services:

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

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

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

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

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Certain imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.

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

3. Wigs for alopecia resulting from chemotherapy or radiation therapy.

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

    a. Surgical implants;

    b. Artificial limbs or eyes;

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

    d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and

    e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end (but not disposable);

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

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

1. Nebulizers, including face masks and tubing. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").

2. Inhaler spacers and peak flow meters. These items are covered under your *prescription drug* benefits (see YOUR PRESCRIPTION DRUG BENEFITS).

3. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

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

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

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

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is a *subscriber,* enrolled *spouse,* or a *domestic partner*.

Transplant Services. Services and supplies provided in connection with a non-*investigative* organ or tissue transplant, if you are:

1. The recipient; or

2. The donor.

If you are the recipient, an organ or tissue donor who is not a member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. *Covered expense* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. *Reasonable charges* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the SUMMARY OF BENEFITS. *Covered expense* does not include charges for services received without first obtaining our prior authorization or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

Specified Transplants

You must obtain our prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants should be performed at *Centers of Medical Excellence (CME)*. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a *CME* will be covered at a lower level of benefits.** Call the toll-free telephone number for pre-service review on your identification card if your *physician* recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a *CME*. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense. The following travel expenses in connection with an approved, specified organ transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a specific *CME* only when the recipient or donor's home is more than 250 miles from the specific *CME*, provided the expenses are approved by us in advance:

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

NOTE: Notwithstanding anything to the contrary above, the overall maximum benefit shall not exceed **$10,000** per transplant.

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at a designated *CME* facility. See UTILIZATION REVIEW PROGRAM for details.

You must obtain pre-service review for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *CME* will not be considered *covered expense.***

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with an approved bariatric surgical procedure only when the *members* place of residence is fifty (50) miles or more from the nearest bariatric *CME.* All travel expenses must be approved by us in advance. The fifty (50) mile radius around the *CME* will be determined by the *bariatric CME coverage area* (See DEFINITIONS).

- Transportation for the *member* to and from the *CME* up to **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *CME* up to **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **$25** per day, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric *CME.* Details regarding reimbursement can be obtained by calling

the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations. This includes human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

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

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

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

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

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

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

Adult Preventive Services. Services and supplies provided in connection with all generally medically accepted cancer screening tests including FDA-approved cancer screenings for cervical cancer and human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer, prostate cancer screenings, colorectal cancer screenings, and the office visit related to those services. Also included is human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. The Calendar Year Deductible will

not apply to these services. Adult Preventive Services are considered to be *preventive care services*. No copayment will apply to these services when they are provided by a *participating provider*.

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

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

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

Allergy. Allergy testing and treatment, including serum.

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

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

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

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

Routine patient care costs do not include the costs associated with any of the following:

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.

2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.

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

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

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

Physical therapy, physical medicine and occupational therapy are limited to 90 visits per calendar year (combined with Speech Therapy).

Chiropractic care is limited to 20 visits per calendar year (combined with Acupuncture).

Contraceptives. Services and supplies provided in connection with the following methods of contraception:

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive

method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians.*

2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

Benefits are provided for one hearing aid per ear every three years.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than one hearing aid per ear every three years.

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").

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease, limited to 90 visits per *calendar year* (combined with Physical therapy, physical medicine & occupational therapy)

HIV Testing. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 20 visits during a *calendar year* (combined with chiropractic care).

If we apply *covered expense* toward the Calendar Year Deductible and do not provide payment, that visit is included in the visit maximum (12 visits) for that *year*.

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

1. The following equipment and supplies:

    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

    b. Insulin pumps.

    c. Pen delivery systems for insulin administration (non-disposable).

    d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

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

2. Diabetes education program which:

   a. Is designed to teach a member who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

   b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and

   c. Is supervised by a *physician*.

   Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following items are covered under your *prescription drug* benefits:

   a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.

   b. Insulin syringes, disposable pen delivery systems for insulin administration.

   c. Testing strips, lancets, and alcohol swabs.

   These items must be obtained either from a retail *pharmacy* or through the mail service program (see YOUR PRESCRIPTION DRUG BENEFITS).

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

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a *pharmacy* and are covered under your *plan's prescription drug* benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a *pharmacy* are covered as medical supplies under your *plan's* medical benefits.

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

Specialty drugs. You can only have your *prescription* for a *specialty drug* filled through the Specialty Drug Program unless you qualify for an exception. The Anthem Blue Cross Life and Health - Specialty Drug Program only fills *specialty drug prescriptions*. The Specialty Drug Program will deliver up to a 30-day supply of your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health). If your *physician* orders the *specialty drug* to be administered in their office, only the medication needed for the visit will be delivered.

Non-duplication of benefits applies to *specialty drugs* under this *plan*. When benefits are provided for *specialty drugs* under the *plan's* medical benefits, they will not be provided under YOUR PRESCRIPTION DRUG BENEFITS, if included. Conversely, if benefits are provided for *specialty drugs* under YOUR PRESCRIPTION DRUG BENEFITS, if included, they will not be provided under the *plan's* medical benefits.

To obtain a *specialty drug* for home use, you must have a *prescription* for the *drug* that states the *drug* name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, that is signed by a *physician*. Your *physician* will be responsible for ordering the *specialty drug* for administration in their office.

You or your *physician* may order your *specialty drug* from Specialty Drug Program by calling 1-800-870-6419. When you or your *physician* call Anthem Blue Cross Life and Health – Specialty Drug

Program, a Dedicated Care Coordinator will guide you or your *physician* through the process up to and including actual delivery of your *specialty drug* to you or your *physician*. (If you order your *specialty drug* by telephone, you will need to use a credit card to debit card to pay for it.) If you order a *specialty drug* for home use, you may also submit your *specialty drug* prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross Life and Health – Specialty Drug Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment, if any. If your *physician* orders the *specialty drug* for administration in their office, you will be responsible for any applicable Co-Payments.

If you order a *specialty drug* for home use, the first time you get a *prescription* for a *specialty drug* you must complete an Intake Referral Form. The Intake Referral Form is completed by telephone by calling 1-800-870-6419. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number, 1-800-870-6419. Co-payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty drugs* available through Specialty Drug Program or order forms by contacting Member Services at the number shown below or online at www.anthem.com/ca.

Anthem Blue Cross Life and Health – Specialty Drug Program

2825 W. Perimeter Road

Indianapolis, IN 46241

Phone 1-800-870-6419

Fax 1-800-824-2642

Prior Authorization. Certain *specialty drugs* require written prior authorization of benefits in order for you to receive them. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the *drug* originally requested. (If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a *drug* other than the one you are currently taking.) If approved, *specialty drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

In order for you to get a *specialty drug* that requires prior authorization, your *physician* must make a request to us for you to get it. The request may be made by either telephone or facsimile to us. At the time the request is initiated, specific clinical information will be requested from your *physician* based on Anthem Blue Cross Life and Health's medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty drug*.

If the request is for urgently needed *drugs*, after we get the request:

- We will review it and decide if we will approve benefits within 72 hours. (As soon as we can, based on your medical condition, as *medically necessary*, we may take less than 72 hours to decide if we will approve benefits.) We will tell you and your *physician* what we have decided - by telephone and in writing by facsimile to your *physician,* and in writing by mail to you.

- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your *physician*, within 24 hours after we get the request, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 24 hours, we will tell your *physician* that there is a

problem as soon as we know that we cannot respond within 24 hours. In either event, we will tell you and your *physician* that there is a problem – in writing by facsimile, and by telephone, to your *physician*, and in writing by mail to you.

- As soon as we can, based on your medical condition, as *medically necessary*, but, not more than 48 hours after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to the *physician* and by mail to you.

If the request is not for urgently needed *drugs*, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as *medically necessary*, we will review it and decide if we will approve benefits within 5 business days. We will tell you and your *physician* what we have decided in writing - by fax to your doctor, and by mail, to you.

- If more information is needed to make a decision, we will tell your *physician* in writing within 5 business days after we get the request–what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 5 business days, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 5 business days. In any event, we will tell you and your *physician* that there is a problem by telephone, and in writing by facsimile, to your *physician*, and in writing to you by mail.

- As soon as we can, based on your medical condition, as *medically necessary*, within 5 business days after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.

While we are reviewing the request for a *specialty drug*, a 72-hour emergency supply of medication may be dispensed to you if your *physician* determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment, if any, shown in SUMMARY OF BENEFITS: MEDICAL AND PRESCRIPTION DRUG BENEFITS: CO-PAYMENTS APPLICABLE TO MEDICAL AND PRESCRIPTION DRUG BENEFITS for the 72-hour supply of your *drug*. If we approve the request for the *specialty drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* after payment of any applicable additional co-payment that could apply.

If you have any questions regarding whether a *specialty drug* requires prior authorization, please call us at 1-800-274-7767.

If we deny a request for prior authorization of a *specialty drug*, you or your prescribing *physician* may appeal our decision by calling us at 1-800-274-7767. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.

Exceptions to Specialty Drug Program. This program does not apply to:

a. The first two-month supply of a *specialty drug* which is available through a participating retail *pharmacy*;

b. *Drugs*, which due to medical necessity, must be obtained immediately; or

c. A member who is unable to pay for delivery of their medication (i.e., no credit card).

How to obtain an exception to the Specialty Drug Program. If you believe that you should not be required to get your medication through the Specialty Drug Program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may

call us at 1-800-274-7767 to request one. You can also get the form on-line at www.anthem.com/ca. If we have given you an exception, it will be in writing and will be good for twelve months from the time it is given. After twelve months, if you believe that you should still not be required to get your medication through the Specialty Drug Program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a *specialty drug* subject to the Specialty Drug Program. If you are out of a *specialty drug* which must be obtained through the Specialty Drug Program, we will authorize an override of the Specialty Drug Program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: MEDICAL AND PRESCRIPTION DRUG BENEFITS: CO-PAYMENTS APPLICABLE TO MEDICAL AND PRESCRIPTION DRUG BENEFITS for the 72-hour supply of your *drug*.

If you order your *specialty drug* through the Specialty Drug Program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the *drug* immediately, we will authorize an override of the Specialty Drug Program requirement for 30-day supply or less, to allow you to get an emergency supply of medication from a *participating pharmacy* near you. A Dedicated Care Coordinator from the Specialty Drug Program will coordinate the exception and you will not be required to make an additional co-payment.

Unless you qualify for an exception, if you don't get your *specialty drug* through the Specialty Drug Program, you will not receive any benefits under this *plan* for them.

MEDICAL CARE THAT IS NOT COVERED

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

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

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 an independent medical review as described in REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.

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.

Uninsured. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

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

Excess Amounts. Any amounts in excess of *covered expense* or any Medical Benefit Maximum.

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

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

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

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

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

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

4. It must accept patients who are unable to pay; and

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

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

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.

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.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.

Note: Services for treatment of *mental or nervous disorders*, substance abuse and *severe mental disorders* are not covered by Anthem Blue Cross Life and Health under this *plan*. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by the *group*. However, copays for services paid to UBH do go toward satisfaction of the out-of-pocket maximum under this *plan*.

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

Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL CARE THAT IS COVERED.

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

Hearing Aids or Tests. Hearing aids, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as specifically provided under the "Well Baby and Well Child Care," "Physical Exam (Members Age 7 and Over)" and "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided under the "Well Baby and Well Child Care," or "Physical Exam (Members Age 7 and Over)" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL CARE THAT IS COVERED.

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

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

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specifically stated in the "Prosthetic Devices" provision.

Commercial Weight Loss Programs. Weight loss programs not approved by us, 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 is covered as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

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

Sterilization Reversal. Reversal of sterilization.

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.

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

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

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

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

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.

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

Education or Counseling. Any educational treatment or nutritional counseling, or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us. Such services are provided under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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

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

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

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

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

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.

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

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

Specialty drugs. *Specialty drugs* that must be obtained from the Specialty Drug Program, but, which are obtained from a retail *pharmacy* are not covered by this *plan*. **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the Specialty Drug Program**.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL CARE THAT IS COVERED.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specifically stated in "YOUR PRESCRIPTION DRUG BENEFITS" section of this booklet.

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

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

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

TRANSGENDER SURGERY BENEFITS

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

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

CONDITIONS FOR COVERAGE

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

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

TRANSGENDER SURGERY DEDUCTIBLES, CO-PAYMENTS AND MAXIMUMS

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

CALENDAR YEAR DEDUCTIBLES

Each *year*, you will be responsible for satisfying the *member's* Calendar Year Deductible before we begin to pay benefits.

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

CO-PAYMENTS

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

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

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

TRANSGENDER SURGERY BENEFIT MAXIMUM

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

TRANSGENDER SURGERY CARE THAT IS COVERED

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

Hospital

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

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

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Professional Services

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

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

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

a. Round trip coach airfare to the facility which is designated by us and approved for the transgender surgery requested, not to exceed **$250** per person per trip.

b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.

c. Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.

TRANSGENDER SURGERY CARE THAT IS NOT COVERED

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

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

Not Authorized. Services or supplies that are not authorized (See UTILIZATION REVIEW PROGRAM for details).

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

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

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

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

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

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

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

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by us for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the mail service program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective generic form of *prescription drugs*.

Prescription drug covered expense will always be the lesser of the billed charge or the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the *drug* for which the charge is made.

When you choose a *participating pharmacy*, the *pharmacy benefits manager* will subtract any expense which is not covered under your *prescription drug* benefits. The remainder is the amount of *prescription drug covered expense* for that claim. You will not be responsible for any amount in excess of the *prescription maximum allowed amount* for the covered services of a *participating pharmacy*.

When the *pharmacy benefits manager* receives a claim for *drugs* supplied by a *non-participating pharmacy*, they first subtract any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *prescription maximum allowed amount*. The remainder is the amount of *prescription drug covered expense* for that claim.

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

PRESCRIPTION DRUG CO-PAYMENTS

After the *pharmacy benefits manager* determines *prescription drug covered expense,* they will subtract your Medical and Prescription Drug Deductible from the total amount they consider *prescription drug covered expense.* After that deductible has been satisfied, they will subtract your Prescription Drug Co-Payment for each *prescription* during the remainder of the *year*.

If your Prescription Drug Co-Payment includes a percentage of *prescription drug covered expense,* then the *pharmacy benefits manager* will apply that percentage to such expense. This will determine the dollar amount of your Prescription Drug Co-Payment.

The Medical and Prescription Drug Deductible and Prescription Drug Co-Payments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a member covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled.

Once you have met your deductible, and provided you have properly identified yourself as a member, a *participating pharmacy* will only charge your Co-Payment.

For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Generic drugs will be dispensed by *participating pharmacies* when the *prescription* indicates a *generic drug*. When a *brand name drug* is specified, but a *generic drug* equivalent exists, the *generic drug* will be substituted. *Brand name drugs* will be dispensed by *participating pharmacies* when the

prescription specifies a *brand name* and states “dispense as written” or no *generic drug* equivalent exists. For all *prescriptions*, you will be charged the lesser of the cost of the drug or the stated copayment. For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, you need to meet your deductible, if any, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager* at the address shown below:

Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Participating pharmacies usually have claim forms, but, if the *participating pharmacy* does not have claim forms, claim forms and customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821), or by visiting our web site at www.anthem.com/ca/uc. Mail your claim, with the appropriate portion completed by the pharmacist, to the *pharmacy benefits manager* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You Go to a Non-Participating Pharmacy. If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to us, at the address below:

Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Non-participating pharmacies do not have our prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it.

Claim forms and customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You are Out of State. If you need to purchase a *prescription drug* out of the state of California, you may locate a *participating pharmacy* by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Mail. You can order your *prescription* through the mail service *prescription drug* program. Not all medications are available through the mail service pharmacy.

The *prescription* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your Co-Payment.

Your first mail service *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. You need only

enclose the *prescription* or refill notice, and the appropriate payment for any subsequent mail service prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.

Order forms can be obtained by contacting:

Prescription Drug Program - Mail Service
PO Box 66558
St. Louis, MO 63166-6558
1-866-274-6825

When You Order Your Prescription Through Specialty Drug Program. You can only order your *prescription* for a *specialty drug* through the Specialty Drug Program unless you are given an exception from the Specialty Drug Program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). Specialty Drug Program only fills *specialty drug* prescriptions. Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross).

The *prescription* for the *specialty drug* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*.

You or your *physician* may order your *specialty drug* by calling 1-877-241-3489. When you call Specialty Drug Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty drug* to you. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your *specialty drug prescription* with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Specialty Drug Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment.

The first time you get a *prescription* for a *specialty drug* you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number. Co-payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty drugs* available through Specialty Drug Program or order forms by contacting Member Services at the number shown below or online at www.anthem.com/ca/uc.

Specialty Drug Program
2825 W. Perimeter Road
Indianapolis, IN 46241
Phone 1-877-241-3489
Fax 1-800-824-2642

If you don't get your *specialty drug* through the Specialty Drug Program, you will not receive any benefits under this *plan* for them.

PRESCRIPTION DRUG UTILIZATION REVIEW

Your prescription drug benefits include utilization review of prescription drug usage for your health and safety. Certain drugs may require prior authorization. If there are patterns of over-utilization or misuse of drugs, our medical consultant will notify your personal physician and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of drugs.

PRESCRIPTION DRUG FORMULARY

We use a *prescription drug formulary* to help your *physician* make prescribing decisions. The presence of a *drug* on the *plan's prescription drug formulary* list does not guarantee that you will be prescribed that *drug* by your *physician*. This list of outpatient *prescription drugs* is developed by a committee of *physicians* and pharmacists to determine which medications are sound, therapeutic and cost effective choices. These medications, which include both generic and *brand name drugs*, are listed in the *prescription drug formulary*. The committee updates the *formulary* quarterly to ensure that the list includes *drugs* that are safe and effective. Note: The *formulary drugs* may change from time to time.

Some *drugs* may require prior authorization. If you have a question regarding whether a particular *drug* is on our *formulary drug* list or requires prior authorization please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Prior Authorization. Certain *drugs* require written prior authorization of benefits in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the *drug* originally requested at the applicable co-payment. (If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, and you underwent a prior authorization process under the prior plan which required you to take different drugs, we will not require you to try a *drug* other than the one you are currently taking.) If approved, *drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

In order for you to get a *drug* that requires prior authorization, your *physician* must make a written request to us for you to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be facsimiled or mailed to us. If your *physician* needs a copy of the form, he or she may call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at www.anthem.com/ca/uc.

If the request is for urgently needed *drugs*, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- We will review it and decide if we will approve benefits within 72 hours. (As soon as we can, based on your medical condition, as *medically nec*essary, we may take less than 72 hours to decide if we will approve benefits.) We will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.
- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your *physician*, within 24 hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 24 hours, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 24 hours. In either event, we will tell you and your *physician* that there is a problem – always in writing by facsimile and, when appropriate, by telephone to your *physician* and in writing by mail to you.
- As soon as we can, based on your medical condition, as *medically necessary*, but, not more than 48 hours after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to the *physician* and by mail to you.

If the request is not for urgently needed *drugs*, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as *medically necessary*, we will review it and decide if we will approve benefits within 5 business days. We will tell you and your *physician* what we have decided in writing - by fax to your *physician*, and by mail, to you.

- If more information is needed to make a decision, we will tell your *physician* in writing within 5 business days after we get the request–what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 5 business days, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 5 business days. In any event, we will tell you and your *physician* that there is a problem in writing by facsimile, and when appropriate, by telephone to your *physician*, and in writing to you by mail.
- As soon as we can, based on your medical condition, as *medically necessary*, within 5 business days after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.

While we are reviewing the Outpatient Prescription Drug Prior Authorization of Benefits form, a 72-hour emergency supply of medication may be dispensed to you if your *physician* or pharmacist determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*. If we approve the request for the *drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* with no additional copayment.

If you have any questions regarding whether a *drug* in on our *prescription drug formulary*, or requires prior authorization, please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

If we deny a request for prior authorization of a *drug*, you or your prescribing *physician* may appeal our decision by calling us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

Revoking or modifying a prior authorization. A prior authorization of benefits for *prescription drugs* may be revoked or modified prior to your receiving the *drugs* for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

New drugs and changes in the *prescription drugs* covered by the *plan*. The outpatient *prescription drugs* included on the list of *formulary drugs* covered by the *plan* is decided by the WellPoint Pharmacy and Therapeutics Committee which is comprised of independent *physicians* and pharmacists. The Pharmacy and Therapeutics Committee meets quarterly and decides on changes to make in the *formulary drug* list based on recommendations from us and a review of relevant information, including current medical literature.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the *drug* or medication must satisfy all of the following requirements:

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.

2. It must be approved for general use by the State of California Department of Health Services or the Food and Drug Administration (FDA).

3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or *drugs* for cosmetic purposes are not included. However formulas prescribed by a *physician* for the treatment of phenylketonuria are covered.

4. It must be dispensed from a licensed retail *pharmacy*, through our mail service program or through our Specialty Drug Program.

5. **If it is an approved *compound medication*, be dispensed by a *participating pharmacy*.** Call 1-888-224-4911 to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a *participating pharmacy* at www.anthem.com/ca/uc.) **Some compound medications must be approved before you can get them (See PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.**

6. **If it is a *specialty drug*, be obtained by using the Specialty Drug Program.** See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY DRUG PROGRAM for how to get your *drugs* by using the Specialty Drug Program. **You will have to pay the full cost of any *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the Specialty Drug Program. If you order a *specialty drug* through the mail service program, it will be forwarded to the Specialty Drug Program for processing and will be processed according to Specialty Drug Program rules.**

   Exceptions to Specialty Drug Program. This requirement does not apply to:

   a. The first two-month supply of a *specialty drug* which is available through a *participating pharmacy*;

   b. *Drugs*, which due to medical necessity, must be obtained immediately;

   c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card); or

   d. A *member* for whom, according to the Coordination of Benefit rules, this *plan* is not the primary plan.

   How to obtain an exception to the Specialty Drug Program. If you believe that you should not be required to get your medication through the Specialty Drug Program, for any of the reasons listed above, except for d., you must complete an Exception to Specialty Drug Program form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at 1-888-224-4911 to request one. You can also get the form on-line at www.anthem.com/ca/uc. If we have given you an exception, it will be in writing and will be good for 12-months from the time it is given. After 12-months, if you believe that you should still not be required to get your medication through the Specialty Drug Program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

   Urgent or emergency need of a *specialty drug* subject to the Specialty Drug Program. If you are out of a *specialty drug* which must be obtained through the Specialty Drug Program, we will authorize an override of the Specialty Drug Program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your *physician* decides that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown under SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*.

   If you order your *specialty drug* through the Specialty Drug Program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the *drug* immediately, we will authorize an override of the Specialty Drug Program requirement for a 30-day supply or less, to

allow you to get an emergency supply of medication from a *participating pharmacy* near you. A Dedicated Care Coordinator from the Specialty Drug Program will coordinate the exception and you will not be required to make an additional co-payment.

7. It must not be used while you are an inpatient in any facility. Also, it must not be dispensed in or administered by an outpatient facility.

8. For UC participating pharmacies, the prescription must not exceed a 90-day supply.

9. For a retail *pharmacy* or through the Specialty Drug Program, the *prescription* must not exceed a 30-day supply.

   Prescription drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder and that require a triplicate prescription form must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of copayment for retail *pharmacies.* If the *drugs* are obtained through the mail service program, the copayment will remain the same as for any other *prescription drug.*

10. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

11. For the mail service program, the *prescription* must not exceed a 90-day supply.

12. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.

13. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria.

2. Insulin.

3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.

4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year*.

5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or *family member*. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.

6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.

7. Diabetic supplies (i.e. test strips and lancets).

8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma.

9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

10. Smoking cessation products requiring a *physician's* prescription.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this *prescription drug* benefit, these items are covered under the "Blood," "Well Baby and Well Child Care," and "Preventive Care or Physical Exam," provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "Hospice Care," "Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "Prescription Drug for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Hospital," "Home Health Care," "Hospice Care," and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

5. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications which may be obtained without a *physician's* written *prescription*, except insulin or niacin for cholesterol lowering.

7. *Drugs* and medications dispensed by or while you are confined in a *hospital*, *skilled nursing facility,* rest home, sanitorium, convalescent hospital, or similar facility. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services",

and “Diabetes” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

9. Services or supplies for which you are not charged.

10. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the “Hospital”, “Skilled Nursing Facility”, “Home Health Care” and “Hospice Care” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

11. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because we determine that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section “Independent Medical Review of Denials of Experimental or Investigative Treatment” (see Table of Contents) for how to ask for a review of your *drug* denial.)

13. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.

14. *Drugs* which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.

15. Over-the-counter smoking cessation *drugs*. This does not apply to *medically necessary drugs* that you can only get with a *prescription* under state and federal law.

16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.

17. *Drugs* used primarily for the purpose of treating infertility, unless *medically necessary* for another covered condition.

18. Anorexiants and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).

19. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the “Hospital”, “Skilled Nursing Facility”, and “Professional Services” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

20. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the “Professional Services” and “Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

21. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the “Special Food Products” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

22. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

23. *Compound medications* obtained from other than a *participating pharmacy*. **You will have to pay the full cost of the *compound medications* you get from a *non-participating pharmacy***.

24. *Specialty drugs* that must be obtained from the Specialty Drug Program, but, which are obtained from a retail *pharmacy* are not covered by this *plan*. **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the Specialty Drug Program**. **If you order a *specialty drug* through the mail service program, it will be forwarded to the Specialty Drug Program for processing and will be processed according to Specialty Drug Program rules.**

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

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

The following criteria are used to create a Benefit Reserve:

1. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

2. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered only under This Plan.

3. If This Plan is the Principal Plan, the benefits under This Plan will be determined without taking into account the benefits or services of any Other Plan. When This Plan is the Principal Plan, nothing will be applied to This Plan's Benefit Reserve.

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-subscriber benefit plans.

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

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

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

EFFECT ON BENEFITS

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

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

EFFECT OF THE BENEFIT RESERVE ON PLAN BENEFITS

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

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

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

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

1. *Members* who are receiving treatment for end-stage renal disease following the first 30 months such *members* are entitled to end-stage renal disease benefits under Medicare; and

2. *Members* who are entitled to Medicare benefits as disabled persons; unless the *members* have a current employment status, as determined by Medicare rules, through a *group* of 100 or more employees (according to OBRA legislation).

3. Retired employees and the spouses of retired employees who are enrolled for Medicare Part A and/or Part B.

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

Electronic Claims Coordination

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

UTILIZATION REVIEW PROGRAM

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

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

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

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays*.
- Transplant services.
- Admissions to a *skilled nursing facility*.
- Bariatric surgical services performed at a *Centers of Medical Excellence* (*CME*) facility.
- Outpatient private duty nursing care services.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.
- Transgender Surgery Benefit services.

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

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

The stages of utilization review are:

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

- Scheduled, non-emergency inpatient *hospital stays* (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
- Transplant services.
- Admissions to a *skilled nursing facility*.
- Bariatric surgical services performed at a *CME* facility.
- Outpatient private duty nursing care services.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.
- Transgender Surgery Benefit services.

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

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital stay*, the benefits to which you would have been otherwise entitled **will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.**
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
   - Scheduled, non-emergency inpatient *hospital stays*.
   - Transplant services as follows:
     a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
     b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures if the providers of the related preoperative and postoperative services are approved.
   - Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
   - Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:
     a. The services are to be performed for the treatment of morbid obesity.
     b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

c. The bariatric surgical procedure will be performed at a *CME* facility.

- Outpatient private duty nursing care services will be provided only if the following criteria are met:

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

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

  c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *member's* medical needs and must list the services to be provided by the licensed nurse (R.N., L.P.N. or L.V.N.).

- Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

- Transgender surgery services and related covered services will be provided as follows:

  a. The Surgical Procedure:

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

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

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

  b. Transgender Surgery Travel Expense:

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

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

If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

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

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed your benefits will be reduced as shown in the "Effect on Benefits".

Pre-service Reviews

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

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

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

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

Concurrent Reviews

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

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

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

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

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

Retrospective Reviews

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

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

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

THE MEDICAL NECESSITY REVIEW PROCESS

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

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

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

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

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

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

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

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

    - an explanation of the reason for the decision,
    - reference of the criteria used in the decision to modify or not certify the request,
    - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
    - how to request reconsideration if you or your provider disagree with the decision.

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

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

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

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

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

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

PERSONAL CASE MANAGEMENT

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

HOW PERSONAL CASE MANAGEMENT WORKS

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

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

1. You require extensive long-term treatment;
2. We anticipate that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. Our cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with our recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

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

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

EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member,* which alternatives may be offered and the terms of the offer.
2. Any authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *member*.
3. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member*.

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

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

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

QUALITY ASSURANCE

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

EXTENSION OF BENEFITS

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

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

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

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

    a. You are no longer totally disabled.

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

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

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

HIPAA COVERAGE AND CONVERSION

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

HIPAA Coverage

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

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

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

Conversion Coverage

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

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

   The three consecutive month period of coverage requirement will be waived for *members* who have been covered under another UC plan then switch to this *plan* during an Open Enrollment and need to convert prior to being covered for three consecutive months under this *plan*.

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

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

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

CERTIFICATION OF CREDITABLE COVERAGE

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

Providers available to you through the BlueCard Program have not entered into contracts with Blue Cross of California. If you have any questions or complaints about the BlueCard Program, please call us at the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement,* both the *agreement* and your coverage under the *agreement* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

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

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

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

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

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

Medical Necessity. The benefits of this *plan* are provided only for services which are *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 *members* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

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

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

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

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

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

Payment to Providers. We will pay the benefits of this *plan* directly to *participating providers*, *CME* and medical transportation providers. Also, we will pay other providers of service directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, we will pay the benefits of this *plan* to that party. These payments will fulfill our obligation to you for those covered services.

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

1. Proof of payment of medical services and the provider's itemized bill for such services;

2. If the *subscriber* does not reside with the patient, either a copy of the judicial order requiring the *subscriber* 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 *subscriber* 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 *subscriber* 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 *subscriber,* the name of the patient, and other necessary information related to the coverage.

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

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

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

Entire Contract. This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *agreement* which includes

this certificate. The terms of the *agreement* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *agreement*.

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

No claim for *covered expense* you incur in connection with a *pre-existing condition* will be reduced or denied after you have been covered for six consecutive months under the *agreement*, unless the disease, illness, injury or physical condition was specifically excluded from coverage by name or description. Also, if you were covered under *creditable coverage,* the time spent under the *creditable coverage* will be used to satisfy, or reduce, the six consecutive month period.

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

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

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

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

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, we will provide benefits at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time we terminate our contractual relationship with the provider (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with us prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with us prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

We will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing

treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by us in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a complaint with us as described in the COMPLAINT NOTICE.

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
    - ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
    - ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
    - ♦ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
    - ♦ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
        a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
        b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
        c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
        d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
        e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

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

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

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

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

Within three business days of receiving notice from the CDI of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

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

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

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

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

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

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

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

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

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

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

BINDING ARBITRATION

THIS PROVISION DOES NOT APPLY TO CLASS ACTIONS

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

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

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

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

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

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) is a health care service plan, regulated by the California Department of Insurance.

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

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of, or 30 minutes normal travel time from, your residence or place of work;

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

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

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

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric *CME*.

Bariatric CME Coverage Area is the area within the 50-mile radius surrounding a designated bariatric *CME*.

Centers of Medical Excellence (CME) are health care providers designated by us as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. CME agree to accept *negotiated rate* as payment in full for covered services. A *participating provider* in the Prudent Buyer Plan network is not necessarily a *CME*.

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

Compound Medication is a mixture of *prescription drugs* and other ingredients, of which at least one of the components is commercially available as a prescription product. Compound medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or

2. Products lacking a National Drug Code (NDC) number.

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

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

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

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

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

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

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Drug (prescription drug) means a prescribed drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public. For the purposes of this *plan,* insulin will be considered a prescription drug.

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. We will have sole and final determination as to whether services were rendered in connection with an emergency.

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

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

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

Formulary drug is a *drug* listed on the *prescription drug formulary*.

Full-time employee meets the *plan's* eligibility requirements for full-time employees outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

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

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

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

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

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

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

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

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

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

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

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

Non-participating pharmacy is a *pharmacy* which does not have a contract in effect with the *pharmacy benefits manager* at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

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

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

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

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank; or

3. A licensed ambulance company.

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

Participating pharmacy is a *pharmacy* which has a Participating Pharmacy Agreement in effect with the *pharmacy benefit manager* at the time services are rendered. Call your local *pharmacy* to determine whether it is a participating pharmacy or call the toll-free customer service telephone number.

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

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

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

Pharmacy means a licensed retail pharmacy.

Pharmacy Benefits Manager (PBM) is the entity with which Anthem has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with Anthem.

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, is providing a service for which benefits are specified in this booklet, and when benefits would be provided if the services were provided by a physician as defined above:

    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist
    f. A chiropractor (D.C.)
    g. An acupuncturist (A.C.)
    h. A licensed clinical social worker (L.C.S.W.)
    i. A marriage and family therapist (M.F.T.)
    j. A physical therapist (P.T. or R.P.T.)*
    k. A speech pathologist*
    l. An audiologist*

m. An occupational therapist (O.T.R.)*
n. A respiratory care practitioner (R.C.P.)*
o. A *psychiatric mental health nurse* (R.N.)*
p. A nurse midwife**
q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

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

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

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the *agreement* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Prescription means a written order or refill notice issued by a licensed prescriber.

Prescription drug covered expense is the expense you incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

Prescription drug maximum allowed amount is the maximum amount allowed for any *drug*. The amount is determined by using prescription drug cost information provided to us by the *pharmacy benefits manager*. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

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

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

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

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

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

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

Psychiatric emergency medical condition is a *mental or nervous 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 or nervous disorder*.

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

Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

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

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

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

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

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

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs which often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail *pharmacies*.

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

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

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

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

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

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

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

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

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

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

FOR YOUR INFORMATION

WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card. 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 providers 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. Our privacy statement can also be viewed on our website.

BELOW IS A LIST OF UC PARTICIPATING PHARMACIES THAT DISPENSE MEDICATION UNDER THE SPECIAL PROGRAM FOR MAINTENANCE DRUGS

The following UC pharmacies participate in the special UC three-month walk-up benefit and the specialty medication programs. This list is subject to change at any time. To confirm if UC pharmacy participation is current or if you have questions, contact the Anthem Blue Cross Life and Health Pharmacy at 800-700-2541.

For details about the pharmacy benefits for the Anthem Blue Cross Life and Health plan in which you are enrolled, see your insurance booklet and/or click on the *Prescription Drugs* section of the UC Anthem web site: http://www.anthem.com/ca/uc/.

UC DAVIS CLINIC PHARMACY
2660 W COVELL BLVD
DAVIS, CA 95616
Phone: 530 759 – 2333

UC DAVIS PRIMARY CARE CENTER OUTPATIENT PHARMACY
2315 STOCKTON BLVD
SACRAMENTO, CA 95817
Phone: 916 734 – 3252

UC DAVIS AMBULATORY CARE CENTER OUTPATIENT PHARMACY
4860 Y STREET
SACRAMENTO, CA 95817
Phone: 916 734 – 6250

UC DAVIS CANCER CENTER OUTPATIENT PHARMACY
4501 X STREET AT 45TH ST
SACRAMENTO, CA 95817
Phone: 916 734 - 5865

EDITH & WILLIAM PERLMAN PHARMACY
9350 CAMPUS POINT DRIVE
LA JOLLA, CA 92037
Phone: 858 657 – 8610

RONALD REAGAN UCLA OUTPATIENT PHARMACY
662 GAYLEY AVE ROOM B-140B
LOS ANGELES, CA 90095
Phone: 310 267 – 8524

UCLA MEDICAL CENTER MAIN OUTPATIENT PHARMACY
10833 LE CONTE AVE
LOS ANGELES, CA 90095
Phone: 310 206 – 4242

UCLA PHARMACY MED. PLAZA LEVEL IV
200 UCLA MEDICAL PLAZA SUITE 426
LOS ANGELES, CA 90095
Phone: 310 794 – 7456

UCLA MEDICAL PLAZA LEVEL 1 PHCY
200 UCLA MEDICAL PLAZA #135
LOS ANGELES, CA 90095
Phone: 310 794 - 1193

UCI MED CTR PHARMACY
101 THE CITY DRIVE ROUTE 32
ORANGE, CA 92868
Phone: 714 456 – 5480

UCI FAMILY HEALTH CTR PHARMACY
800 NORTH MAIN STREET
SANTA ANA, CA 92701
Phone: 714 480 – 2497

UCSD IMG CLINIC PHARMACY
8939 CILLA LA JOLLA #100
LA JOLLA, CA 92037
Phone: 858 543 – 6191

UCSD MOORES CANCER CENTER
3855 HEALTH SCIENCES DR #0845
LA JOLLA, CA 92093-0845
Phone: 858 543 - 6194

UCSD AMBULATORY CARE CLINIC PHARMACY
4168 FRONT STREET
SAN DIEGO, CA 92103
Phone: 619 543 – 5934

UCSD MEDICAL GROUP PHARMACY
330 LEWIS STREET
SAN DIEGO, CA 92103
Phone: 619 471 – 9235

UCSD MEDICAL CENTER PHARMACY
200 WEST ARBOR DRIVE
SAN DIEGO, CA 92103
Phone: 619 543 – 2682

COMPLAINT NOTICE

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

Anthem Blue Cross Life and Health Insurance Company
Customer Service
21555 Oxnard Street
Woodland Hills, CA 91367

818-234-2700

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

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: "Consumer Services" link at www.insurance.ca.gov