PPO Plan
Outside of California Without Medicare
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 Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the Group Policy upon request.

Your health care coverage is insured by BC Life & Health Insurance Company (BC Life). The following pages describe your health care benefits and includes the limitations and all other policy provisions which apply to you. The member is referred to as “you” or “your,” and BC Life as “we,” “us” or “our.” All italicized words have specific policy definitions. These definitions can be found in the DEFINITIONS section of this certificate.
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University of California – PPO Plan
Outside of California Without Medicare

BENEFITS AT A GLANCE

This is a brief review of your benefits. For complete information, including the terms and conditions of this plan and exclusions and limitations, please refer to the entire Summary Plan Description.

Calendar year deductible (PPO & Non-PPO calendar year deductibles are exclusive of each other)

<table>
<thead>
<tr>
<th>Providers &amp; Other Health Care Providers</th>
<th>PPO: $250/member; $750/family</th>
<th>Non-PPO: $500/member/$1,500 family</th>
</tr>
</thead>
</table>

Penalty for not obtaining preauthorization where required: $200/occurrence

Annual out-of-pocket maximums (PPO & Non-PPO out-of-pocket maximums are exclusive of each other)

<table>
<thead>
<tr>
<th>Providers &amp; Other Health Care Providers</th>
<th>PPO: $3,000/member/year; $9,000/family/year</th>
<th>Non-PPO: $6,000/member/year; $18,000/family/year</th>
</tr>
</thead>
</table>

The following do not apply to out-of-pocket maximums: percentage copays for behavioral health services; prescription drug copays; non-covered expense; non-compliance penalty charges; charges in excess of customary and reasonable charges. After a member reaches the out-of-pocket maximum, the member remains responsible for behavioral health services; prescription drug copays; non-compliance penalties; costs in excess of customary and reasonable charges; costs in excess of the covered expense.

Lifetime Maximum $2,000,000/member

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Member Copay</th>
<th>Non-PPO: Per Member Copay</th>
</tr>
</thead>
</table>

### Hospital Medical Services

- Semi-private room, meals & special diets, & ancillary services: 20% & 40%
- Outpatient medical care, surgical services & supplies: 20% & 40%

### Ambulatory Surgical Centers

- Outpatient surgery, services & supplies: 20% & 40%

### Skilled Nursing Facility (preauthorization required)

- Semi-private room, services & supplies (limited to 240 days/calendar year): 20% & 40%

### Hospice Care

- Inpatient or outpatient services for members with up to one year life expectancy: 20% & 20%

### Home Health Care (preauthorization required)

- Services & supplies from a home health agency (limited to 100 visits/calendar, home health aide equals four visits/year, one home health aide visit equals four hours of care; not covered while member receives hospice care): 20% & 40%

### Registered Special Duty Nurse (outpatient only; preauthorization required)

- 20% & 40%

### Home Infusion Therapy (preauthorization required)

- Includes medication, ancillary services, and supplies; 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 (including mammograms, Pap smears, & prostate cancer screenings)

- 20% & 40%
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Member Copay</th>
<th>Non-PPO: Per Member Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Routine physical exams, immunizations, diagnostic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray &amp; lab for routine physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-birth to age 7</td>
<td>No copay</td>
<td></td>
</tr>
<tr>
<td>-age 7 &amp; older</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Vision Exams <em>(when medically necessary)</em></td>
<td>20%</td>
<td>Not covered</td>
</tr>
<tr>
<td>✓ Hearing Exams</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Hearing Aids <em>(&lt;2,000 maximum; maximum 2 hearing aids every 36 months, analog and digital devices are covered)</em></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>✓ Allergy testing &amp; treatment <em>(including serums)</em></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Physical Therapy, Physical Medicine &amp; Occupational Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Outpatient speech therapy following injury or organic disease</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Services for the treatment of disease, illness or injury</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Disorders <em>(preauthorization required)</em></strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Splint therapy &amp; surgical treatment</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Family planning services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Infertility studies &amp; tests</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Tubal ligation</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Vasectomy</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Counseling &amp; consultation</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Elective abortion</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Pregnancy &amp; Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Physician office visits</td>
<td>20% (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Prescription drug for elective abortion <em>(mifepristone)</em></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Normal delivery, cesarean section, complications of pregnancy &amp; abortion <em>(newborn routine nursery care covered)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Inpatient physician services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>✓ Hospital &amp; ancillary services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Organ &amp; Tissue Transplants <em>(preauthorization required)</em></strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Inpatient services provided in connection with non-investigative organ or tissue transplants</td>
<td>20%</td>
<td>Not covered</td>
</tr>
<tr>
<td>✓ Physician office visits <em>(including specialists and consultants)</em></td>
<td>20%</td>
<td>Not covered</td>
</tr>
<tr>
<td>✓ Transplant travel expense for an authorized, specified transplant <em>(recipient &amp; companion transportation for round-trip coach airfare, $100/day for 7 days)</em></td>
<td>No copay <em>(deductible waived)</em></td>
<td></td>
</tr>
<tr>
<td>✓ Transplant travel expense for an authorized, specified transplant <em>(recipient &amp; companion transportation for round-trip coach airfare, $100/day for 7 days)</em></td>
<td></td>
<td>$25/day/person/trip &amp; $100/day for 7 days)</td>
</tr>
<tr>
<td>✓ MedCall* <em>(a 24-hour service that connects members to a nurse or audio library with a toll-free call; the number is printed on the member’s ID card)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Diabetes Education Programs <em>(requires physician supervision)</em></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>✓ Prosthetic Devices <em>(coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; &amp; the first pair of contact lenses or eyeglasses when required as a result of eye surgery)</em></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Covered Services</td>
<td>PPO: Per Member Copay</td>
<td>Non-PPO: Per Member Copay</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental or purchase of DME including dialysis equipment &amp; supplies, &amp; therapeutic shoes &amp; inserts for members with diabetes</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Related Outpatient Medical Services &amp; Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or air ambulance transportation, services &amp; disposable supplies</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Blood transfusions, blood processing &amp; the cost of unreplaced blood &amp; blood products</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Autologous blood <em>(self-donated blood collection, testing, processing &amp; storage for planned surgery)</em></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services &amp; supplies</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Inpatient hospital services &amp; supplies</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Ambulatory surgical center services &amp; supplies</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Physician services</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Covered Services (outpatient prescriptions only)</th>
<th>Per Member Copay for Each Prescription or Refill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Pharmacy</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Generic drugs</td>
<td>$15</td>
</tr>
<tr>
<td>➢ Brand name formulary drugs</td>
<td>$25</td>
</tr>
<tr>
<td>➢ Brand name non-formulary drugs</td>
<td>$40</td>
</tr>
<tr>
<td>➢ Contraceptive Devices; Diabetic supplies</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Mail Service</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Generic drugs</td>
<td>$30</td>
</tr>
<tr>
<td>➢ Brand name formulary drugs</td>
<td>$50</td>
</tr>
<tr>
<td>➢ Brand name non-formulary drugs</td>
<td>$80</td>
</tr>
<tr>
<td>➢ Contraceptive Devices; Diabetic supplies</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Non-participating Pharmacies</strong></td>
<td>50% of average wholesale price schedule plus charges in excess of the schedule (waived in an emergency)</td>
</tr>
<tr>
<td><strong>Supply Limits</strong></td>
<td></td>
</tr>
<tr>
<td>➢ Retail Pharmacy</td>
<td>30-day supply for retail prescriptions except a 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)</td>
</tr>
<tr>
<td>➢ Mail Service</td>
<td>90-day supply</td>
</tr>
</tbody>
</table>

The copays for members traveling out of the country will be the same as for Participating Pharmacies.
UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2003

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"). Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), they are only eligible to enroll in the plan if they meet the Plan’s geographic service area criteria. Anyone enrolled in a nonUniversity Medicare + Choice Managed Care contract is not eligible for 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. 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)."

\(^*\)For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12) month period.

(a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

(a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.
Annuitant: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Survivor Annuitant: A deceased Employee's or Annuitant's family member receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as an Annuitant when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a Survivor Annuitant when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Annuitant medical eligibility;
(b) the effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death for a Survivor Annuitant); and
(c) you elect to continue medical coverage at the time of retirement.

If you are eligible for Medicare, see "Effect of Medicare on Annuitant 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. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse: Your legal spouse. (Note: if you are a Survivor Annuitant, you may not enroll your legal spouse.)

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

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

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous,
- the child is dependent on you for at least 50% of his or her support and is your dependent for income tax purposes, and
UNIVERSITY OF CALIFORNIA
ELIGIBILITY, ENROLLMENT, TERMINATION AND
PLAN ADMINISTRATION PROVISIONS

- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members): You may enroll as an adult relative or same sex domestic partner (and the same sex domestic partner’s children/grandchildren) as set forth in the University of California Group Insurance Regulations.

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California’s Customer Service Center.

No Dual Coverage
Eligible individuals may be covered under only one of the following categories: as an Employee, an Annuitant, a Survivor Annuitant or a Family Member, but not under any combination of these. If both husband and wife are eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's coverage but not under both.

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

During a Period of Initial Eligibility (PIE)
A PIE ends 31 days after it begins.

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

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

(a) For a spouse, on the date of marriage. Survivor Annuitants may not add Spouses to their coverage.
(b) For a natural child, on the child’s date of birth.
(c) For an adopted child, the earlier of:
  • the date you or your Spouse has the legal right to control the child's health care, or
  • the date the child is placed in your physical custody.

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

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

If you decline enrollment for yourself or your eligible Family Members because of other group medical
plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those
eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO and you move or are transferred out of that HMO’s service area, or will be away
from the HMO’s service area for more than two months, you will have a PIE to enroll yourself and
your eligible Family Members in another University medical plan. Your PIE starts with the effective
date of the move or the date you leave the HMO’s service area.

At Other Times

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

If you or your eligible Family Members fail to enroll during a PIE or open enrollment period, you may
enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-
day waiting period starts on the date your enrollment form is received by the local Accounting or
Benefits office and ends 90 consecutive calendar days later.

If you have two or more Family Members enrolled in the Plan, you may add a newly eligible Family
Member at any time. See “Effective Date”.

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

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 an Annuitant 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.

When you already have two or more Family Members enrolled and enroll another Family Member,
coverage may be retroactive with the effective date limited to the later of:

(a) the date the newly added Family Member becomes eligible, or
(b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

Effect of Medicare on Annuitant Enrollment

If you are an Annuitant and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Annuitants and their Family Members who are eligible for premium free Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. Annuitants or Family Members who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Affidavits may be obtained from the University's Customer Service Center. (Annuitants/Family Members who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to the Annuitant Insurance unit at Office of the President.

Medicare Private Contracting Provision

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as an Annuitant by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.
However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

TERMINATION OF COVERAGE

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

Deenrollment Due to Loss of Eligible Status
If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

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

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

Deenrollment Due to Fraud
Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 18 months.

Leave of Absence, Layoff or Retirement
Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage
If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UCbencom website (www.ucop.edu/bencom). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Annuitant.
By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Policy. What is written in this document does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

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

**Sponsorship and Administration of the Plan**

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California  
Human Resources and Benefits  
300 Lakeside Drive, 5th Floor  
Oakland, CA 94612-3557  
(800) 888-8267

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

Claims under the Plan are processed by BC Life & Health Insurance Company at the following address and phone number:

BC Life & Health Insurance Company  
21555 Oxnard Street  
Woodland Hills, CA 91367

BC Life & Health Insurance Company’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, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the
Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California’s annual budget appropriation.

Financial Arrangements. The benefits under the Plan are provided by BC Life & Health Insurance Company under a Group Policy. 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 BC Life & 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 Policy, at a time and location mutually convenient to the participant and the Plan Administrator.

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

Claims under the Plan. To file a claim or to appeal a denied claim, refer to pages 58, 60, 61 and 62 of this document.

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

Please send inquiries regarding the University’s affirmative action and equal opportunity policies for staff to Director Mattie Williams, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.
TYPES OF PROVIDERS

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

Participating Providers. There are two kinds of participating providers in this plan:

- **PPO Providers** are primarily hospitals and physicians who participate in a BlueCard PPO network and have agreed to provide PPO members with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers.

- **Traditional Providers** are providers who might not participate in a BlueCard PPO network, but have agreed to provide PPO members with health care services at a discounted rate.

The level of benefits we will pay under this plan is determined as follows:

- If your plan identification card (ID card) shows a PPO suitcase logo and:
  - You go to a PPO Provider, you will get the higher level of benefits of this plan.
  - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this plan.

- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this plan.

Please call the toll-free BlueCard Provider Access number on your ID card to find a participating provider in your area. A directory of PPO Providers is available.

Non-Participating Providers. Non-participating providers are hospitals and physicians which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the negotiated rates and other provisions.

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.

Other Health Care Providers. "Other Health Care Providers" are neither physicians nor hospitals. They are mostly free-standing facilities, such as skilled nursing 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 participating providers.

Reproductive Health Care Services. Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility testing; or abortion. You should obtain more information before you enroll. Call your prospective physician or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.
Participating and Non-Participating Pharmacies. “Participating Pharmacies” agree to charge only the prescription drug negotiated rate to fill the prescription. You pay the lesser of your co-payment amount or the cost of the drug.

“Non-Participating Pharmacies” have not agreed to the prescription drug negotiated rate. The amount that will be covered as prescription drug covered expense is significantly lower than what these providers customarily charge.
SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH WE DETERMINE 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 NOTICE ABOUT YOUR MEDICAL BENEFITS

Your plan has Utilization Review Program and Authorization Program requirements. These are explained in the Medical Management section beginning on page 47. Your benefits may be reduced if you do not follow the procedures outlined. If you have any questions about the Utilization Review Program or Authorization Program requirements, call us at the toll-free number on your identification card.
MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

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<thead>
<tr>
<th>Participating providers and other health care providers</th>
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<td>• Member Deductible ...........................................</td>
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<td>• Family Deductible ...........................................</td>
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<td>Non-participating providers</td>
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<td>• Member Deductible ...........................................</td>
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<tr>
<td>Non-Certification Deductible ...................................</td>
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**EXCEPTIONS:** In certain circumstances, one or more of these deductibles may not apply, as described below:

- The Calendar Year Deductible will not apply to physician’s services for routine examinations and immunizations provided under Well Baby and Well Child Care when the services are provided by a participating provider.
- The Calendar Year Deductible will not apply to Preventive Care services when the services are provided by a participating provider.
- The Calendar Year Deductible will not apply to office visits for pregnancy and maternity care when the services are provided by a participating provider.
- The Calendar Year Deductible will not apply to transplant travel expenses authorized by us. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.
- The Non-Certification Deductible will not apply to emergency admissions or services. See MEDICAL MANAGEMENT PROGRAMS: UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

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

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<tbody>
<tr>
<td>• Participating Providers</td>
<td>20%</td>
</tr>
<tr>
<td>• Other Health Care Providers</td>
<td>20%</td>
</tr>
<tr>
<td>• Non-Participating Providers</td>
<td>40%</td>
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</tbody>
</table>

*Exceptions:

- You are not required to make Co-Payment for services of a physician for routine physical examinations and immunizations for a child less than seven years of age.
- 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.
  - Emergency services provided by other than a hospital;
b. The first 48 hours of emergency services provided by a hospital (the participating provider Co-Payment will continue to apply to a non-participating provider beyond the first 48 hours if, in our judgment, you cannot be safely moved);

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

d. Charges by a type of physician not represented in a Blue Cross and/or Blue Shield Plan (for example, an audiologist);

e. Outpatient Speech Therapy;

f. Cancer Clinical Trials; or

g. Diabetes Education Programs.

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

− If you receive services from an other health care provider of a type participating in a Blue Cross and/or Blue Shield Plan, your Co-Payment if you go to a provider participating in the Blue Cross and/or Blue Shield Plan will be the same as for a participating provider shown above. But, if you go to a provider not participating in the Blue Cross and/or Blue Shield Plan, your Co-Payment will be the same as for non-participating provider shown above.

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

NOTE: In addition to the Co-Payments 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.

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

Per Member:

• Participating providers .......................................................... $3,000

• Non-participating providers ................................................... $6,000

Per Family:

• Participating providers .......................................................... $9,000

• Non-participating providers ................................................... $18,000

Exceptions:

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

  -- Outpatient prescription drugs covered under YOUR PRESCRIPTION DRUG BENEFITS section of this plan description.

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

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

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

Skilled Nursing Facility
- For covered skilled nursing facility care ........................................................................... 240 days per calendar year

Home Health Care
- For covered home health services ................................................................................. 100 visits per calendar year

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

- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the transplant center ................................................................. $250 for round trip coach airfare
  - For hotel accommodations ......................................................................................... $100 per day, for up to 7 days
  - For expenses such as meals....................................................................................... $25 per day, up to 7 days

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

Lifetime Maximum
- For all medical benefits .............................................................................................. $2,000,000 during your lifetime

IMPORTANT NOTE

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG CO-PAYMENTS. The following co-payments apply for each prescription or refill:

Participating Pharmacies. The following co-payments apply for a 30-day supply of medication.

- **Generic Drugs** ...................................................................................................................... $15*
- **Brand Name Drugs:**
  -- Formulary drugs and non-formulary drugs when the prescriber has specified “dispense as written” ........................................................ $25*
  -- Non-formulary brand name drugs ........................................................................................ $40*
- **Contraceptive Diaphragms and Diabetic Supplies** ......................................................... No charge

*You pay the lesser of the Co-Payment above or the cost of drug.

When you present a prescription to a participating pharmacy, the pharmacist will advise you about the copay that would apply and also if there are any other instructions. If the participating pharmacy indicates your prescription cannot be filled, you or your pharmacist can call the Blue Cross pharmacy customer services and they will clarify. If you have to pay the full cost of the prescription drug, submit a claim for reimbursement.

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

Non-Participating Pharmacies. The following co-payments apply for a 30-day supply of medication.

- **Generic Drugs or Brand Name Drugs** ....................................................................................... 50% of the drug limited fee schedule (that is, the lesser of the billed charges or the average wholesale price). In addition, you are responsible for costs in excess of the drug limited fee schedule.

Mail Service Program. The following co-payments apply for a 90-day supply of medication.

- **Generic Drugs** ............................................................................................................................... $30
- **Brand Name Drugs:**
  -- Formulary drugs and non-formulary drugs when the prescriber has specified “dispense as written” ........................................................ $50
  -- Non-formulary brand name drugs .............................................................................................. $80
- **Contraceptive Diaphragms and Diabetic Supplies** ................................................................. No charge
Important Note About *Prescription Drug Covered Expense* and Your Co-Payment.

- The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. Your co-payment amount for *non-formulary drugs* is higher than for *formulary drugs*. You can obtain information about the formulary by calling our pharmacy customer service toll-free number or by accessing the Blue Cross UC website (www.bluecrossca.com/uc). Any *participating pharmacy* can assist you in purchasing a *formulary drug*.

- *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*.

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**PRESCRIPTION DRUGS OBTAINED OUTSIDE THE UNITED STATES**

When you obtain a *prescription drug* while you are out of the country, you will have to pay the full cost of the *drug* to the *pharmacy* and submit a claim to us at the address below:

Prescription Drug Program  
P.O. Box 4165  
Woodland Hills, CA 91365-416

We will reimburse you **100%** of the cost of the *drug*, less the applicable Participating Pharmacy copay. (For information on how to submit a claim, please refer to the "When You Go to a Non-Participating Pharmacy" provision in the YOUR PRESCRIPTION DRUG BENEFITS section of this certificate.)
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. The maximum covered expense for services provided by a participating provider will be the lesser of the billed charge or the negotiated rate. Participating providers have agreed not to charge you more than the negotiated rate for covered services. When you choose a participating provider, you will not be responsible for any amount in excess of the negotiated rate.

If you 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 be performed by participating providers whenever you enter a hospital.

Note: If an other health care provider is participating in a Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a participating provider for the purposes of determining covered expense.

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 reasonable 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 or other health care provider, in excess of the lesser of the maximum covered expense stated above, or:
   a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
   b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this plan.
DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

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

DEDUCTIBLES

Each deductible under this plan is separate and distinct from the other. Only charges that are considered covered expense will apply toward satisfaction of any deductible.

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

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

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

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

CO-PAYMENTS

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

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

OUT-OF-POCKET AMOUNTS

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

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

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

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

- Medical Management Program penalties that may apply;
- Expense which is incurred for non-covered services or supplies;
- Expense which is in excess of the amount of covered expense;
- Co-Payments made for outpatient prescription drugs covered under YOUR PRESCRIPTION DRUG BENEFITS section of this plan description; and
- Co-Payments made for services covered through United Behavioral Health, your mental health care benefits carrier.

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

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

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

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

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

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

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

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

In no event will benefits exceed 100 visits during a calendar year. One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your physician and submitted to us. Covered services are available on a 24-hour basis for the management of your condition.
1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient hospital care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

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

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

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

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

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

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

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

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

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); but medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

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

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

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

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

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

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

If you do not obtain the required authorization, your benefits may be reduced. See MEDICAL MANAGEMENT PROGRAMS for details. Private duty nursing services for custodial care is not covered.
“Private duty” means a session of four or more hours that continuous nursing care is furnished to you alone.

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

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

Ambulance. The following ambulance services:
1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a “911” emergency response system* request for assistance if you believe you have an emergency medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest hospital where appropriate treatment is provided if, and only if, such services are medically necessary and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

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

Diagnostic Services. Outpatient diagnostic radiology and laboratory services.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices
1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. We will pay for other medically necessary prosthetic devices, including:
   a. Surgical implants;
   b. Artificial limbs or eyes; and
   c. The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery.
**Durable Medical Equipment.** Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

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

**Dental Care**

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

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

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

**Pregnancy and Maternity Care**

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

2. Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is enrolled under the plan.

**Organ and Tissue Transplants.** Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

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

If you do not obtain the required authorization, your benefits may be reduced. Also, covered expense does not include charges for services that are provided by a non-participating provider. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.
Transplant Travel Expense. The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a transplant center, provided the expenses are authorized by us (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.):

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

2. For the donor, per transplant episode, limited to one trip:
   a. Round trip coach airfare to the transplant center, not to exceed $250.
   b. Hotel accommodations, not to exceed $100 per day for up to 7 days.
   c. Other expenses, such as meals, not to exceed $25 per day, for up to 7 days.

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

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

Preventive Care (Members Age 19 and Over). The following services for members age 19 years and over:

1. Physician’s services for routine physical examinations.
2. Radiology and laboratory services in connection with routine physical examinations.
3. Immunizations.

Hearing Exams. Hearing examinations.

Vision Exams. Vision screening for determining medical necessity of a vision examination. NOTE: Vision exam services are covered only if provided by a participating provider.

Allergy. Allergy testing and treatment, including serum.

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

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

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

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a medically necessary mastectomy.

4. Breast prostheses following a mastectomy (see “Prosthetic Devices”).

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

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all 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 does 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.
Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a physician under a treatment plan which offers a reasonable expectation of significant improvement:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

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

Family Planning. Family planning services, counseling and planning for problems of fertility and infertility, as medically necessary. Diagnosis and testing for infertility. Infertility treatment, including GIFT, ZIFT, artificial insemination, in vitro fertilization, and any related laboratory procedures are not covered.

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

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

2. Surgically implanted hearing devices (i.e., cochlear implants, auditon 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.

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

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

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

   These covered equipment and supplies are covered under your plan’s benefits for durable medical equipment (see “Durable Medical Equipment”).

2. Diabetes education program which:
   a. Is designed to teach a 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:
   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.

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

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

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

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

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

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

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

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

**Special Food Products.** Special food products and formulas that are part of a diet prescribed by a physician for the treatment of phenylketonuria (PKU). 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.
MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

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

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

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

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

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

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

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

**Excess Amounts.** Any amounts in excess of covered expense or the Lifetime Maximum.
**Exercise Equipment.** Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a physician.

**Experimental or Investigative.** Any experimental or investigative procedure or medication.

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

**Government Treatment.** Any services provided by a local, state, or federal government agency, except when payment under this plan is expressly required by federal law or state law.

**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 provided as part of routine physical examinations under “Well Baby and Well Child Care”, “Preventive Care” or “Hearing Aid Services” provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

**Mental Disorders.** Academic or educational testing, counseling, and remediation. Mental disorders or chemical dependency, including rehabilitative care in relation to these conditions.

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

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

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

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

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

**Obesity.** Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of morbid obesity as determined by us if we authorize the treatment in advance as medically necessary and appropriate.

**Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except routine eye screenings provided as part of routine physical examinations under “Well Baby and Well Child Care” or “Preventive Care” benefits of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the “Prosthetic Devices and Durable Medical Equipment” provision of MEDICAL CARE THAT IS COVERED.

**Orthodontia.** Braces and other orthodontic appliances or services.
Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the “Prosthetic Devices and Durable Medical Equipment” 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 And Occupational Therapy” 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.

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

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

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

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

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

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

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

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

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

Sterilization Reversal. Reversal of sterilization.

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

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

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;

3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

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

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

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers’ compensation, employer’s liability law or occupational disease law, even if you do not claim those benefits.
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, but, not more than the amount allowed by California Civil Code Section 3040.

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 we will accept 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 amount shown below. Expense is incurred on the date you receive the drug for which the charge is made.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Maximum Prescription Drug Covered Expense is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Pharmacies and Mail Service Program</td>
<td>Prescription Drug Negotiated Rate</td>
</tr>
<tr>
<td>Non-Participating Pharmacies</td>
<td>Drug Limited Fee Schedule Amount</td>
</tr>
</tbody>
</table>

When we receive a claim for drugs supplied by a non-participating pharmacy, we will first subtract any expense which is not covered under your prescription drug benefits, and then any expense exceeding the drug limited fee schedule. *(That is, the lesser of the billed charges or the average wholesale price.)* 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 or which is in excess of prescription drug covered expense.

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. Provided you have properly identified yourself as a member, a participating pharmacy will only charge your Co-Payment.

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.

Many participating pharmacies display an "Rx" decal with the Blue Cross logo in their window. For information on how to locate a participating pharmacy in your area, call 1-800-700-2541.

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, 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 at the address shown below:

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

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms and customer service are available by calling 1-800-700-2541. Mail your claim, with the appropriate portion completed by the pharmacist, to 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, at the address below:

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

Non-participating pharmacies do not have Blue Cross' 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. Mail your claim with the appropriate portion completed by the pharmacist to 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 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  
P.O. Box 550  
Pittsburg, PA 15230-9424  
1-888-888-DRUG
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 (e.g., Viagra, Enbrel, Celebrex, Vioxx, Growth Hormone and Lotronex). 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

The plan uses a prescription drug formulary to help your doctor make prescribing decisions. 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 the formulary drug list or requires prior authorization please call 1-800-700-2541. You may also use the Blue Cross website at www.bluecrossca.com/uc to view the formulary drug list or get information about a specific drug.

If we deny a request for prior authorization of a drug that is not part of the formulary drug list, you or your prescribing physician may appeal our decision by calling 1-800-700-2541.

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 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, or through your mail service program.
5. 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.
6. For a retail pharmacy, 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.
7. Certain drugs have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.
8. For the mail service program, the prescription must not exceed a 90-day supply.
9. The drug will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your plan.
10. 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. These formulas are subject to the copayment for brand name drugs.

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 and are not subject to any copayment.

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). Diabetic supplies are not subject to any copayment.

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

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.

2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable drugs or medications.

3. Drugs and medications used to induce spontaneous and non-spontaneous abortions.

4. Drugs and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient hospital facilities and physicians’ offices.

5. Professional charges in connection with administering, injecting or dispensing of drugs.

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.

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.

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

11. Cosmetics and health or beauty aids.

12. Drugs that are limited by Federal Law to “Investigational Use” or experimental drugs. Drugs or medications prescribed for experimental indications.

13. Any expense incurred for a drug or medication in excess of: (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate, for drugs dispensed by participating pharmacies or through the mail service program.

14. Drugs which have not been approved for general use by the Food and Drug Administration.

15. Smoking cessation drugs.

16. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles).

17. Drugs used primarily for the purpose of treating infertility (including but not limited to Clomid, Pergonal, and Metrodin).

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.

20. Infusion drugs, except drugs that are self-administered subcutaneously.


22. Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.
COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

Other Plan is any of the following:

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

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

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

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

EFFECT ON BENEFITS

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

ORDER OF BENEFITS DETERMINATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Electronic Claims Coordination**

If you are covered by Medicare, call us at 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.
MEDICAL MANAGEMENT PROGRAMS

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

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

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

UTILIZATION REVIEW PROGRAM

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

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

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

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

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency hospital admissions and ambulatory surgical center services.

2. **Concurrent review** determines whether services are medically necessary and appropriate when pre-service review is not required or we are notified while service is ongoing, for example, an emergency admission to the hospital.

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.
EFFECT ON BENEFITS

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

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

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.

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

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

Concurrent Reviews

1. If pre-service review was not performed, you 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. The toll-free number is printed on your identification card.

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

3. If we determine that the service is not medically necessary and appropriate, your physician will be notified by telephone no later than 24 hours following our decision. You and your physician will receive written notice no later than one business day following our decision.
Retrospective Reviews

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

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

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

AUTHORIZATION PROGRAM

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

It is your responsibility to obtain authorization before you receive any service subject to the authorization program. The toll-free number to call for authorization is shown on your plan identification card. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the “Effect on Benefits” portion of AUTHORIZATION PROGRAM.

SERVICES REQUIRING AUTHORIZATION

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

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

Special Services

1. Organ and tissue transplants.
2. Transplant travel expense benefits.
3. Home health care.
4. Home infusion therapy.
5. Splint therapy services or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull.
6. Outpatient private duty nursing services.
7. Admissions to a skilled nursing facility.

EFFECT ON BENEFITS

For Services Requiring Authorized Referral

1. The Co-Payment for participating providers will apply for medically necessary and appropriate authorized referral services received from a non-participating provider.
2. The Co-Payment for non-participating providers will apply for referral services received from non-participating providers that have not been authorized in advance.

For Special Services. When the appropriate authorization is not obtained, the benefits to which you would have been otherwise entitled will be reduced by $200 for each occurrence. In addition, services for organ and tissue transplants are not covered when performed by a non-participating provider.

WHEN AUTHORIZATION WILL BE PROVIDED

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

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

2. The services are authorized as medically necessary before services are received.

Special Services

1. Organ and Tissue Transplants. Authorizations for organ and tissue transplants will be provided only if both of the following criteria are met:
   a. The services are medically necessary; and
   b. The physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

2. Transplant Travel Expense Benefits. Authorizations for transplant travel expense benefits will be provided for the recipient or donor only if all of the following criteria are met:
   a. It is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, authorized by us;
   b. The organ transplant must be performed at a transplant center approved by us; and
   c. The transplant center is 250 miles or more from the recipient or donor’s home.

3. Home Health Care. Authorizations for home health care services will be provided only if the following criteria are met:
   a. The services are medically necessary and appropriate and can be safely provided in the member’s home, as certified by the attending physician.
   b. The attending physician manages and directs the member’s medical care at home.
   c. The attending physician must establish a definitive treatment plan which must be consistent with the member’s medical needs and must list the services to be provided by the home health agency.

4. Home Infusion Therapy. Authorizations for services by a home infusion therapy provider will be provided only if the following criteria are met:
   a. The services are medically necessary and appropriate; and
   b. The attending physician has submitted both a prescription and a plan of treatment prior to services being rendered.

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

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

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

   a. You require daily skilled nursing or rehabilitation, as certified by the attending *physician*;
   
   b. You were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and
   
   c. You will be treated for the same condition for which you were treated in the *hospital*.

**HOW TO OBTAIN AN AUTHORIZATION**

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

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

**THE MEDICAL NECESSITY REVIEW PROCESS**

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

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

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

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

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

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

6. A written confirmation including the specific service certified as *medically necessary* will be sent to you and your provider no later than 2 business days from the decision.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical reviewer is unable to certify the service, the requesting physician is contacted telephonically for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary and appropriate. Your physician will be notified telephonically 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 one business day 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 chose at our sole and absolute discretion.

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

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

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

PERSONAL CASE MANAGEMENT

The personal case management program enables us to authorize you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. 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. Any alternative benefits are accumulated toward the Lifetime Maximum.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any member, which alternatives may be offered and the terms of the offer.
3. 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.
4. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other member.

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

**DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS**

1. If you or your physician disagree with a decision, or question how it was reached, you or your physician may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
2. If you, your representative, or your physician acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.
3. If the appeal decision is still unsatisfactory, your remedy is binding arbitration. (See BINDING ARBITRATION.)
QUALITY ASSURANCE

Medical management programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Resource Management Committee, Quality Management Committee, and Physician Relation’s 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 policy, 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 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 Post-COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medicaid, or any group medical coverage and cannot have other medical coverage.

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

Conversion Coverage

To apply for a conversion plan, you must submit an application to us within 31 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 policy terminates and is replaced by another group plan within 60 days.
2. You are not eligible if your coverage under this plan ends because premium is not paid when due because you (or the subscriber who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this plan ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the plan for three consecutive months immediately prior to the termination of your coverage.

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

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.
**Important:** The intention of conversion coverage is not to replace the coverage you have under this *plan*, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

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

**CERTIFICATION OF CREDITABLE COVERAGE**

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

Blue Cross and/or Blue Shield Providers. When you obtain services, your coinsurance and other insured person liability for covered services is calculated on the lower of the actual billed charges for your covered services or the negotiated price that is passed along to us by the provider’s Blue Cross and/or Blue Shield Plan. The negotiated price can simply reflect the final actual discount on a claim. Often the negotiated price will consist of an estimated final price to reflect contractual adjustments that will occur at a later date. The estimated price may be based on the expected adjustment for the particular provider involved or for all or a specified group of the local Plan’s providers. Also in one of a small number of states, your coinsurance and other insured person liability for covered services will be calculated using a discount off billed charges that is an average discount reflecting the local Plan’s anticipated savings for all or a specified group of its providers. Estimated or average prices may be prospectively adjusted to correct for overestimation or underestimation of past prices.

Finally, local Blue Cross and/or Blue Shield Plans in a small number of states are required by statute to use a basis for calculating insured person liability for covered items that does not reflect the entire savings realized or expected to be realized on the claim. When you receive covered health care services in one of these states, your liability for covered services will be calculated using the state’s statutory methods.

Terms of Coverage

1. In order for you to be entitled to benefits under the policy, both the policy and your coverage under the policy 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 policy is subject to amendment, modification or termination according to the provisions of the policy 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 policy.

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

**Medical Necessity.** The benefits of this *plan* are provided only for services which we determine to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States.

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

Workers’ Compensation Insurance. The policy 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 policy which includes this certificate. The terms of the policy 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 policy.

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 policy. 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.

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 policy which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.
REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because we determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care. To request this review, please call us at the telephone number listed on your identification card or write to us at BC Life & 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.
- The proposed treatment must be recommended by either (a) a participating provider or (b) a board certified or board eligible physician qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
- If this review is requested either by you or by a qualified non-participating provider (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:
  a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
  b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
  c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
  d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
  e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
  f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five days of receiving your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your physician. Information we receive subsequently will be sent to the review panel within five business days. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.
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 (“DOI”) if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part because the service is not medically necessary.

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

**Eligibility:** The DOI 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 may bring it immediately to the DOI’s attention. The DOI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

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

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

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

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

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

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

The arbitration is begun by the member making written demand on BC Life. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the member and BC Life, or by order of the court, if the member and BC Life cannot agree. The arbitration will be held at a time and location mutually agreeable to the member and BC Life.
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.

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

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

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

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

**Average wholesale price** is a term accepted in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

**Brand name prescription drug (brand name drug)** is a prescription drug that has been patented and is only produced by one manufacturer.

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

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

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

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

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

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

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

Drug (prescription drug) means a prescribed drug approved by the Food and Drug Administration for general use by the public. For the purposes of this plan, insulin will be considered a prescription drug.

Drug limited fee schedule represents the maximum amounts we will allow as prescription drug covered expense for prescriptions filled at non-participating pharmacies. These amounts are the lesser of billed charges or the average wholesale price.

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or 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 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.

Generic prescription drug (generic drug) is a pharmaceutical equivalent of one or more brand name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand name drug.

Group refers to the business entity to which we have issued this policy. 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 we determine to be:

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

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

**Mental or nervous disorders** are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.
Some mental or nervous disorders are: schizophrenia, manic-depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; adjustment reactions; reactions to stress; hyperkinetic syndromes; attention deficit disorders; learning disabilities; conduct disorder; oppositional disorder; mental retardation; autistic disease of childhood; anorexia nervosa and bulimia.

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 Participating Provider Agreements.

**Non-participating pharmacy** is a pharmacy which does not have a Participating Pharmacy Agreement in effect with us 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 a hospital or physician NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. 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 facility which provides diagnostic radiology services;
3. A blood bank;
4. A durable medical equipment outlet;
5. A clinical laboratory;
6. A *skilled nursing facility*;
7. A *home health agency*;
8. A licensed ambulance company;
9. A hospice;
10. An *ambulatory surgical center*;
11. A *home infusion therapy provider*; or

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 us 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 a hospital or physician participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. *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.
**Physician** means:

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

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:
   a. A dentist (D.D.S.)
   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 midwife
   i. A clinical social worker (L.C.S.W.)
   j. A marriage and family therapist (M.F.T.)
   k. A physical therapist (P.T. or R.P.T.)*
   l. A speech pathologist*
   m. An audiologist*
   n. An occupational therapist (O.T.R.)*
   o. A respiratory care practitioner (R.C.P.)*
   p. A psychiatric mental health nurse (R.N.)*
   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.

**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 **policy** we have issued to the **group**. If changes are made to the plan, an amendment or revised booklet will be issued to the **group** for distribution to each **employee** affected by the change.

**Policy** is the Group Policy we have issued to the **group**.

**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 maximum amounts described in items 1 and 2 below. Expense is incurred on the date you receive the service or supply.

Prescription drug covered expense does not include any expense in excess of: (1) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (2) the prescription drug negotiated rate, for drugs dispensed by participating pharmacies or by the mail service program.

**Prescription drug formulary (formulary)** is a list which we have developed of outpatient prescription drugs which may be cost-effective, therapeutic choices. Any participating pharmacy can assist you in purchasing drugs listed on the formulary.

**Prescription drug negotiated rate** is the rate that we have negotiated with participating pharmacies under a Participating Pharmacy Agreement for prescription drug covered expense. Participating
Pharmacies have agreed to charge members no more than the prescription drug negotiated rate. It is also the rate which Prescription Drug Program - Mail Service accepts as payment in full for mail service prescription drugs.

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 that 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 health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

1. Qualified to provide short-term inpatient treatment according to state law;
2. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
3. Staffed by an organized medical or professional staff which includes a physician as medical director.

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

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

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

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

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

Spouse meets the plan’s eligibility requirements for spouses as 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 members are family members who are unable to perform all activities usual for persons of that age.
**Totally disabled retired employee** is a retired employee who is unable to perform all activities usual for persons of that age.

**Totally disabled subscribers** are subscribers who, because of illness or injury, are unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who are in fact unemployed.

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

**We (us, our)** refers to BC Life & Health Insurance Company.

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

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

WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card. BC Life is an affiliate of Blue Cross of California. You may use Blue Cross of California’s web site to access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card. Simply log on to [www.bluecrossca.com/uc](http://www.bluecrossca.com/uc). Access of the "Member Services" segment of the website requires a PIN. If you do not have a Personal Identification Number (PIN), you can request one at this page and it will be sent to you within seven (7) business days.
MedCall

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

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

- **Home self-care.** A follow-up phone call may be made to determine how well home self-care is working.

- **Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your physician.** If you do not have a physician, the nurse will help you select one by providing a list of physicians who are participating providers in your geographical area.

- **Call your physician for further discussion and assessment.**

- **To go to an emergency room in a participating provider hospital.**

- **Instructions to immediately call 911.**

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

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

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