

UNIVERSITY OF CALIFORNIA

Effective January 1, 2017

UC Medicare PPO

Plan ID#280509

Benefit Booklet

This Benefit Booklet ("*benefit booklet*") describes the terms and conditions of coverage for your UC Medicare PPO. The *plan* document must be consulted to determine the exact terms and conditions of coverage. Be sure you understand the *benefits* offered under this *plan* before receiving services.

Benefits of this *plan* are available only for *covered services* and supplies furnished during the term the *plan* is in effect and while the individual claiming *benefits* is actually covered by this *plan*.

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

The *member* and covered *dependents* are referred to in this booklet as "you" and "your". The *plan administrator* is The Regents of the University of California, which has delegated certain duties to Anthem Blue Cross Life and Health Insurance Company. The *plan administrator* is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found in the DEFINITIONS section of this booklet starting at page 61.

Please read this *benefit booklet* carefully so that you understand all the *benefits* your *plan* offers. Keep this *benefit booklet* handy in case you have any questions about your coverage.

Important: The Regents of the University of California is the Employer. Anthem Blue Cross Life and Health Insurance Company has been appointed the *claims administrator*. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross processes and reviews the claims submitted under this *plan*. This is not an insured benefit plan. The *benefits* described in this *benefit booklet* or any rider or amendments are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

COMPLAINT NOTICE

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

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

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SUMMARY OF BENEFITS

Note: This *plan* is a complement to your existing *Medicare* plan. Only services and supplies that *Medicare* determines to be allowable and medically necessary are covered under this Supplement Plan. *Medicare* *benefits* are primary and then the *benefits* of this *plan* are calculated to coordinate up to the *Medicare* allowable amount. For services and supplies which *Medicare* does not cover, the *plan* will provide *benefits* as outlined below.

The SUMMARY OF BENEFITS represents only a brief description of the *benefits*. Please read this booklet carefully for a complete description of *covered services* and exclusions of the *plan*

Each year the U.S. Department of Health and Human Services publishes a *Medicare* handbook entitled *Medicare & You*. This handbook outlines the *benefits* *Medicare* provides and includes any changes in *deductibles*, *copayments*, or *benefits* that may occur from year to year. To obtain a copy, contact your nearest Social Security office, visit the Web site www.medicare.gov or call 1-800-MEDICARE. See the DEFINITIONS section starting at page 61 for the meaning of italicized terms.

Member Calendar Year Deductible for Medicare and Non-Medicare Covered Services	Deductible Amount
<p>Calendar Year Deductible</p> <p><i>Applies to non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by this plan</i></p>	\$100 per Member

Member Maximum Calendar Year Out-of-Pocket Responsibility for Medicare and Non-Medicare Covered Services	Member Maximum Calendar Year Out-of-Pocket Amount
<p>Calendar Year Out-of-Pocket Maximum</p> <p><i>Applies to member copayments and deductibles within Medicare allowable amounts for Medicare covered services and the plan's maximum allowed amounts for non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by this plan.</i></p>	\$1,500

Member Maximum Lifetime Benefits	Maximum Claims Administrator Payment
Lifetime Benefit Maximum	No maximum

SUMMARY OF SUPPLEMENTAL MEDICARE BENEFITS

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

A *benefit period* begins on the first day you receive *covered services* as an inpatient in a *hospital* and ends after you have been out of the *hospital* and have not received skilled care in any other facility for 60 consecutive days.

Benefit ¹	Medicare Pays (in 2017)	Plan Pays	Member Pays
Medicare Part A^{2,3,4,5}			
Hospitalization – Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,316	\$1,316 (Part A Deductible ²)	\$0
61 st through 90 th day	All but \$329 a day	80% of remaining <i>Medicare eligible expenses</i>	20% of remaining <i>Medicare eligible expenses</i>
91 st day and after while using 60 lifetime reserve days	All but \$658 a day	80% of remaining <i>Medicare eligible expenses</i>	20% of remaining <i>Medicare eligible expenses</i>
Once lifetime reserve days are used – additional days	\$0	80% of <i>Medicare eligible expenses</i>	20% of <i>Medicare eligible expenses</i>
Beyond the additional 365 days (Please refer to the section, Medical Care That Is Covered for <i>hospital</i> coverage after you have exhausted both the <i>Medicare</i> lifetime reserve days and the additional 365 day hospitalization benefit.)	\$0	80% of <i>Medicare eligible expenses</i>	20% of <i>Medicare eligible expenses</i>
Skilled Nursing Facility Care⁶ – Must meet <i>Medicare</i> 's requirements including having been in a <i>hospital</i> at least 3 days and entered a <i>Medicare</i> -approved facility within 30 days after leaving the <i>hospital</i> .			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$164.50 a day	80% of remaining <i>Medicare eligible expenses</i>	20% of remaining <i>Medicare eligible expenses</i>
101 st day and after	\$0	\$0	You pay all the costs
Blood⁷			
First 3 pints	\$0	80% of remaining <i>Medicare eligible expenses</i>	20% of remaining <i>Medicare eligible expenses</i>
Additional amounts	100%	\$0	\$0

Benefit ¹	Medicare Pays (in 2017)	Plan Pays	Member Pays
Medicare Part A ^{2,3,4,5}			
Hospice Care			
Must meet <i>Medicare's</i> requirements, including a <i>physician's</i> certification of terminal illness	All but very limited <i>copayment</i> for outpatient drugs and inpatient respite care	80% of remaining <i>Medicare eligible expenses</i>	20% of remaining <i>Medicare eligible expenses</i>

**MEDICARE (PART B)
MEDICARE SERVICES PER CALENDAR YEAR**

Benefit¹	Medicare Pays (in 2017)	Plan Pays	Member Pays
Medicare Part B^{3,5,8}			
Ambulance Services – <i>Emergency ground transportation to a hospital or skilled nursing facility for medically necessary services and transportation in any other vehicle could endanger your health. Medicare will pay for transportation in an airplane or helicopter if you require immediate and rapid ambulance transportation that ground transportation can't provide.</i>	80%	80% of remaining Medicare eligible expenses	20% of remaining Medicare eligible expenses ⁸
Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment⁸ – Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$183 of Medicare approved amounts (Deductible) ⁸	\$0	\$183 (Part B Deductible ⁸)	\$0
Remainder of Medicare approved amounts	Generally 80%	80% of remaining Medicare eligible expenses	20% of remaining Medicare eligible expenses
Part B Excess Charges (above the plan's maximum allowed amount)	\$0	\$0	You pay all the costs
Blood⁷			
First 3 pints	\$0	80% of Medicare eligible expenses	20% of Medicare eligible expenses
Next \$183 of Medicare approved amounts ⁸	\$0	Up to \$183 (Part B Deductible ⁸)	\$0
Remainder of Medicare approved amounts	80%	80% of remaining Medicare eligible expenses	20% of remaining Medicare eligible expenses
Clinical Laboratory Services			
Tests for diagnostic services	80%	80% of remaining Medicare eligible expenses	20% of remaining Medicare eligible expenses
Home Health Care (Medicare Approved Services)			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0

Benefit ¹	Medicare Pays (in 2017)	Plan Pays	Member Pays
Medicare Part B ^{3,5,8}			
Durable Medical Equipment⁹ Covered equipment or supplies and replacement or repair services must be obtained from a <i>Medicare</i> approved supplier for <i>Medicare</i> to pay.			
First \$183 each <i>calendar year</i> (Deductible ⁸)	\$0	Up to \$183 (Part B Deductible ⁸)	\$0
Remainder of <i>Medicare</i> approved amounts	80%	80% of remaining <i>Medicare eligible expenses</i>	20% of remaining <i>Medicare eligible expenses</i>
Part B Excess Charges (above the <i>plan's maximum allowed amount</i>)	\$0	\$0	You pay all the costs

Medicare Covered Services Footnotes

1. Only *retired employees* and their *spouses* or *domestic partners* enrolled in *Medicare* Parts A & B are eligible for this *Medicare* PPO Plan. *Medicare* will always pay primary for *Medicare covered services*. The *plan* will coordinate with *Medicare*, paying secondary.
2. The Part A Deductible of \$1,316 applies to *covered services* and items for *hospital* inpatient care, *skilled nursing facility* care, home health care, *hospice* care and blood. The *deductible* must be paid before *Medicare* begins providing payment for these Part A *covered services*. The *Medicare* PPO Plan pays the Part A Deductible for you.
3. A *member* may select any licensed *physician*, provider, or *hospital* that accepts *Medicare*, for treating a *covered illness* or injury within the United States. This *plan* will always pay secondary to *Medicare* for *Medicare covered services*. The *plan* will pay secondary using *Medicare* allowed amounts subtracting the *Medicare* Part A or Part B Deductible where applicable and the amount paid by *Medicare*.
4. A *benefit period* begins on the first day you receive service as an inpatient in a *hospital* and ends after you have been out of the *hospital* and have not received skilled care in any other facility for 60 days in a row.
5. Inpatient services which are *medically necessary* to treat the acute medical complications of detoxification are covered, but are not considered to be treatment of the substance abuse condition itself.
6. The “Skilled Nursing Facility Care Benefit” is measured in *benefit period*. A *benefit period* is defined as 100 days or less of confinement in an approved *Medicare* facility, and the *benefit* is subject to preconditions before *Medicare* approves the care.
7. For blood covered by *Medicare* Part A, in most cases, the *hospital* gets blood from a blood bank at no charge, and you won’t have to pay for it or replace it. If the *hospital* has to buy blood for you, the *claims administrator* will pay the *hospital* costs for the first 3 units of blood you get in a *calendar year* or you can have the blood donated by you or someone else. For blood covered under *Medicare* Part B, in most cases, the provider gets blood from a blood bank at no charge, and you won’t have to pay for it or replace it. If the provider has to buy blood for you, the *claims administrator* will pay 80% of the provider costs for the first 3 units of blood you get in a *calendar year* or you can have the blood donated by you or someone else. After the first 3 units of blood, *Medicare* will pay 80% of approved amounts and the *claims administrator* will pay 80% of the remaining eligible amount and you pay 20% of the remaining eligible amount.
8. The Part B Deductible of \$183 applies to *covered services* and items for doctor’s services, hospital outpatient care, home health, *preventive care services* and durable equipment. The deductible must be paid before *Medicare* begins providing payment for these Part B *covered services*. The *Medicare* PPO Plan pays the Part B Deductible for you.
9. Durable medical equipment must be obtained from a *Medicare*-approved supplier for *Medicare* to pay. They are listed at www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633-4227 and for TTY users 1-877-486-2048).

MEDICAL BENEFITS

The SUMMARY OF BENEFITS represents only a brief description of the *benefits*. Please read this booklet carefully for a complete description of *covered services* and exclusions of the *plan*.

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

Benefit	Member Pays
Acupuncture Benefits	
<ul style="list-style-type: none"> Acupuncture services – office location <p>The <i>plan</i> will pay for up to 24 visits per member during a <i>calendar year</i>. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes for maximums that apply to your <i>plan</i>.</p> <p>Note: Services are not covered by <i>Medicare</i></p>	20%
Advanced Imaging Procedure Benefits	
<ul style="list-style-type: none"> Facility services (<i>hospital</i> or freestanding surgical center) 	20%, if covered by <i>Medicare</i>
<ul style="list-style-type: none"> <i>Physician</i> services 	20%, if covered by <i>Medicare</i>
Allergy Testing and Treatment Benefits	
<ul style="list-style-type: none"> Testing and treatment, includes serum and serum injections 	20%, if covered by <i>Medicare</i>
<ul style="list-style-type: none"> Allergy serum purchased separately for treatment 	20%, if covered by <i>Medicare</i>
Ambulance Benefits	
<ul style="list-style-type: none"> <i>Emergency</i> or authorized transport (air and ground) 	20%, if covered by <i>Medicare</i>
Ambulatory Surgery Center Benefits	
<ul style="list-style-type: none"> Facility services (<i>hospital</i> or freestanding surgical center) 	20%, if covered by <i>Medicare</i>
<ul style="list-style-type: none"> <i>Physician</i> services 	20%, if covered by <i>Medicare</i>
Chiropractic Benefits	
<ul style="list-style-type: none"> <i>Chiropractic</i> services – office location 	20%, if covered by <i>Medicare</i>
Clinical Trial of Cancer and Other Life Threatening Conditions Benefits	
<p>Coverage is provided for routine patient costs you receive as a <i>member</i> in an approved clinical trial. The services must be those that are listed as covered by this <i>plan</i> for <i>members</i> who are not enrolled in a clinical trial.</p>	20%, if covered by <i>Medicare</i>

Benefit	Member Pays
Diabetes Care Benefits	
<ul style="list-style-type: none"> • Devices, equipment and supplies 	20%, if covered by <i>Medicare</i>
<ul style="list-style-type: none"> • Diabetes self-management training – office location 	20%, if covered by <i>Medicare</i>
Durable Medical Equipment Benefits	
Specific durable medical equipment	20%, if covered by <i>Medicare</i>
Emergency Room Benefits	
<ul style="list-style-type: none"> • Emergency room services - facility 	20%, if covered by <i>Medicare</i>
<ul style="list-style-type: none"> • Emergency room services resulting in an admission 	20%, if covered by <i>Medicare</i>
Hearing Aid Benefits	
<ul style="list-style-type: none"> • Hearing Aid <p><i>Benefits</i> will be provided for two hearing aids per 36-months. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your <i>plan</i>.</p> <p>Note: Services are not covered by <i>Medicare</i></p>	20%
Home Health Care Benefits	
<ul style="list-style-type: none"> • Home health care agency services <p>Home health care services are subject to pre-service review to determine medical necessity. Please refer to <i>Medicare</i> for information on how to obtain the proper reviews.</p>	No charge, if covered by <i>Medicare</i>
Hospice Care Benefits	
<ul style="list-style-type: none"> • The services and supplies are covered when provided by a <i>hospice</i> for the palliative treatment of pain and other symptoms associated with a terminal disease. 	20%, if covered by <i>Medicare</i>

Benefit	Member Pays
Hospital Benefits	
<ul style="list-style-type: none"> • Inpatient services and supplies, provided by a <i>hospital</i> <p><i>Hospital</i> services are subject to pre-service review to determine whether <i>medically necessary</i>. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews after <i>Medicare</i> benefits are exhausted.</p> <p>When you have used all of your <i>Medicare</i> Part A <i>benefit</i> days during a <i>benefit period</i> and all of your <i>Medicare</i> lifetime reserve days are exhausted, the <i>plan</i> will provide additional <i>hospital benefits</i> for the remainder of that <i>benefit period</i></p>	
– Facility fees for the first 60 days	No charge, if covered by <i>Medicare</i>
– Facility fees for 61 st through 91 st day	20%, if covered by <i>Medicare</i>
– Facility fees 91 st day and after while using 60 lifetime reserve days	20%, if covered by <i>Medicare</i>
– Facility fees - once lifetime reserve days are used – additional days	20%, if authorized
– Facility fees - beyond the additional 365 days	20%, if authorized
• Outpatient surgery including freestanding facilities	20%, if covered by <i>Medicare</i>
• Outpatient Physician Services	20%, if covered by <i>Medicare</i>
• Outpatient Diagnostic Services including freestanding facilities	20%, if covered by <i>Medicare</i>
• Outpatient Physical, Physical Medicine, Occupational and Speech therapy services	20%, if covered by <i>Medicare</i>
Mental Health Conditions and Substance Abuse	
<ul style="list-style-type: none"> • Inpatient services and supplies, provided by a <i>hospital</i> <p><i>Hospital</i> services are subject to pre-service review to determine whether <i>medically necessary</i>. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews after <i>Medicare</i> benefits are exhausted. <i>Medicare</i> may apply different limitations on Mental Health and/or Substance Abuse services; please refer to <i>Medicare</i> for a complete set of <i>Medicare</i> guidelines.</p>	
– Facility fees for the first 60 days	No charge, if covered by <i>Medicare</i>
– Facility fees for 61 st through 91 st day	20%, if covered by <i>Medicare</i>
– Facility fees 91 st day and after while using 60 lifetime reserve days	20%, if covered by <i>Medicare</i>
– Facility fees - once lifetime reserve days are used – additional days	20%, if authorized

Benefit	Member Pays
– Facility fees - beyond the additional 365 days	20%, if authorized
– Outpatient Partial Hospitalization	20%, if authorized
– Inpatient Residential Treatment	20%, if authorized
<ul style="list-style-type: none"> • Outpatient office visits Includes office visits with all licensed behavioral health providers, including psychiatrists, psychologists, Marriage, Family and Child Counselors (MFT, MFCC) 	<p style="text-align: center;">20%, if covered by <i>Medicare</i> 20%, if not covered by <i>Medicare</i></p>
Preventive Care Benefits	
<ul style="list-style-type: none"> • <i>Preventive care services</i> <p>See <i>Medicare</i> and page 24 under Medical Care That Is Covered for details for information about your <i>preventive care services</i>.</p>	<p style="text-align: center;">20%, if covered by <i>Medicare</i></p>
<ul style="list-style-type: none"> • Travel Immunizations Benefits 	
– ACA Travel Vaccinations	20%
– Hepatitis A	20%
– Hepatitis B	20%
– Meningitis	20%
– Polio	20%
<ul style="list-style-type: none"> • Other Travel Vaccinations 	
– Japanese Encephalitis	20%
– Rabies	20%
– Typhoid	20%
– Yellow Fever	20%
Professional (Physician) Benefits	
• Inpatient <i>physician</i> services	20%, if covered by <i>Medicare</i>
• Outpatient <i>physician</i> services, other than an office setting	20%, if covered by <i>Medicare</i>
• <i>Physician</i> home visits	20%, if covered by <i>Medicare</i>
<ul style="list-style-type: none"> • <i>Physician</i> office visit 	<p style="text-align: center;">20%, if covered by <i>Medicare</i></p>
• Chemotherapy and radiation therapy services	20%, if covered by <i>Medicare</i>
• Hemodialysis services	20%, if covered by <i>Medicare</i>
• Office based injectable service	20%, if covered by <i>Medicare</i>

Benefit	Member Pays
• Urgent Care services	20%, if covered by <i>Medicare</i>
Prosthetic Devices Benefits	
• <i>Physician</i> services	20%, if covered by <i>Medicare</i>
• Prosthetic devices	20%, if covered by <i>Medicare</i>
Skilled Nursing Facility Benefits	
<i>Hospital</i> services are subject to pre-service review to determine whether <i>medically necessary</i> . Please refer to <i>Medicare</i> for information on how to obtain the proper reviews.	
• Facility fees for the 21st through 100th day	20%, if covered by <i>Medicare</i>
• Facility fees for the 101st day and after	Not covered
Transgender Benefits Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	
• <i>Hospital</i> inpatient services	20%
• <i>Hospital</i> outpatient surgery services	20%
• <i>Physician</i> services	20%

Medical Benefit Summary Notes

Calendar Year Deductible. The *calendar year deductible* per *member* is shown on the SUMMARY OF BENEFITS. The *deductible* applies to non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by the *plan*.

Copayments. After you have met your *calendar year deductible*, and any other applicable *deductible*, you will be responsible for either a percentage or a set-dollar *copayment* of the *maximum allowed amount* as shown in the SUMMARY OF BENEFITS plus all amounts in excess of the *maximum allowed amount*.

Out-of-Pocket Amount. After you have met the total out-of-pocket payments as shown in the SUMMARY OF BENEFITS for *copayments* and *deductibles* you incur during a *calendar year*, you will no longer be required to pay a *copayment* for the remainder of that *year*, but you remain responsible for costs in excess of the *maximum allowed amount*.

Note: Expense which is *incurred* for non-covered services or supplies, or which is in excess of the *maximum allowed amount* will not be applied toward your out-of-pocket amount.

Medical Benefit Maximums

The *plan* does not make *benefit* payments for any *member* in excess of any of the Medical Benefit Maximums.

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

INTRODUCTION

Your *employer* has agreed to be subject to the terms and conditions of Anthem's *provider* agreements which may include pre-service review and utilization management requirements, coordination of *benefits*, timely filing limits, and other requirements to administer the *benefits* under this *plan*.

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

This *plan* contains many important terms (such as “*medically necessary*” and “*maximum allowed amount*”) that are defined in the DEFINITIONS section starting at page 61. When reading through this booklet, consult the DEFINITIONS section to be sure that you understand the meaning of these italicized words.

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

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

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

All benefits are subject to coordination with benefits.

The <i>benefits</i> of this <i>plan</i> are subject to the SUBROGATION AND REIMBURSEMENT section.

YOUR MEDICAL BENEFITS

Maximum Allowed Amount

General

This section describes the term *maximum allowed amount* as used in this *benefit booklet*, and what the term means to you when obtaining *covered services* under this *plan*. The *maximum allowed amount* is the total reimbursement payable under your plan for *covered services* you receive. It is the *plan's* payment towards the service billed by a *hospital, physician or other health care provider* combined with any *deductible* or *copayment* owed by you. In some cases, you may be required to pay the entire *maximum allowed amount*. For instance, if you have not met your *calendar year deductible* under this *plan*, then you could be responsible for paying the entire *maximum allowed amount* for *covered services*. You may be billed by the *physician, hospital or other health care provider* for the difference between its charges and the *maximum allowed amount*. In many situations, this difference could be significant.

When you receive *covered services*, the *claims administrator* will, to the extent applicable, apply claim processing rules to the claim submitted. The *claims administrator* uses these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the *maximum allowed amount* if the *claims administrator* determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your *physician* submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the *maximum allowed amount* will be based on the single procedure code.

Type of Provider. For *covered services* performed by a *physician, hospital, or other health care provider*, the *maximum allowed amount* for this *plan* will be based on the *claims administrator's* applicable rate or fee schedule for this *plan*, an amount negotiated by the *claims administrator* or a third party vendor which has been agreed to by the *physician, hospital or other health care provider*, an amount derived from the total charges billed, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, the *claims administrator* will update such information, which is unadjusted for geographic locality, no less than annually.

Providers who are contracted for other products with the *claims administrator* may have provisions in their contracts that affect the *maximum allowed amount* for this *plan* and for other products for which they are not contracted. For this *plan*, the *maximum allowed amount* for services from these *providers* will be one of the methods shown above unless the contract between the *claims administrator* and that *provider* specifies a different amount.

Physicians, hospitals, and other health care providers may send you a bill and collect for the amount of the *physician's, hospital's, or other health care provider's* charge that exceeds the *maximum allowed amount* under this *plan*.

Exception: If *Medicare* is the primary payor, the *maximum allowed amount* does not include any charge:

1. By a *hospital*, in excess of the approved amount as determined by *Medicare*; or
2. By a *physician or other health care provider*, in excess of the lesser of the *maximum allowed amount* stated above, or:
 - a. For *providers* who accept *Medicare* assignment, the approved amount as determined by *Medicare*; or
 - b. For *providers* who do not accept *Medicare* assignment, the limiting charge as determined by *Medicare*.

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

Crediting Prior Plan Coverage

If you were covered by the *plan administrator's prior plan* immediately before the *plan administrator* signs up with the *claims administrator*, with no lapse in coverage, then you will get credit for any accrued *calendar year deductible* and, if applicable and approved by the *claims administrator*, out-of-pocket amounts under the *prior plan*. This does not apply to individuals who were not covered by the *prior plan* on the day before the *plan administrator's* coverage with the *claims administrator* began, or who join the *plan administrator* later.

If the *plan administrator* moves from one of the *claims administrator's* plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued *calendar year deductible* and out-of-pocket amounts, if applicable and approved by the *claims administrator*. Any maximums, when applicable, will be carried over and charged against the medical benefit maximums under this *plan*.

If the *plan administrator* offers more than one of the *claims administrator's* products, and you change from one product to another with no break in coverage, you will get credit for any accrued *calendar year deductible* and, if applicable, out-of-pocket amounts and any maximums will be carried over and charged against medical benefit maximums under this *plan*.

If the *plan administrator* offers coverage through other products or carriers in addition to the *claims administrator's*, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued *calendar year deductible*, out-of-pocket amount, and any medical benefit maximums under this *plan*.

This Section Does Not Apply To You If:

- The *plan administrator* moves to this *plan* at the beginning of a *calendar year*;
- You change from one of the *claims administrator's* individual policies to the *plan administrator's* plan;
- You change employers; or
- You are a new *member* of the *plan administrator* who joins after the *plan administrator's* initial enrollment with the *claims administrator*.

Conditions of Coverage

The following conditions of coverage must be met for expense *incurred* for services or supplies to be covered under this *plan*.

1. You must incur this expense while you are covered under this *plan*. Expense is *incurred* on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in Medical Care That Is Covered. Additional limits on covered charges are included under specific *benefits* and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in Medical Care That Is NOT Covered. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this *plan*.

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

Medical Care That Is Covered

Subject to *Medicare* guidelines, 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, the *plan* will provide *benefits* for the following services and supplies:

Acupuncture Benefits. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The *plan* will pay for up to 24 visits during a *calendar year*.

Advanced Imaging Procedure Benefits. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging.

Allergy Testing and Treatment Benefits. Allergy testing and treatment, including serum and serum injections.

Ambulance Benefits. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

- For ground ambulance, you are transported:
 - From your home, or from the scene of an accident or medical *emergency*, to a *hospital*,
 - Between *hospitals*, including when you are required to move from a *hospital* that does not contract with the *claims administrator* to one that does, or
 - Between a *hospital* and a *skilled nursing facility* or other approved facility.
- For air or water ambulance, you are transported:
 - From the scene of an accident or medical *emergency* to a *hospital*,
 - Between hospitals, including when you are required to move from a *hospital* that does not contract with the *claims administrator* to one that does, or
 - Between a *hospital* and another approved facility.

All non-emergency ambulance services (ground, air or water) are subject to medical necessity reviews. Emergency ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical emergency. When using an air ambulance in a non-emergency situation, the *claims administrator* reserves the right to select the air ambulance *provider*. If you do not use the air ambulance the *claims administrator* selects in a non-emergency situation, no coverage will be provided by the *plan* and you will be responsible for the entire cost of transport.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *physician* are not a *covered service*.

Other non-covered ambulance services include, but are not limited to, trips to:

- A *physician's* office or clinic;
- A morgue or funeral home.

If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this *plan* will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such as a skilled nursing facility), or if you are taken to a *physician's* office or to your home.

Hospital to hospital transport: If you are being transported from one *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats you cannot give you the medical services you need. Certain specialized services are not available at all *hospitals*. For example, burn care, cardiac care, trauma care, and critical care are only available at certain *hospitals*. For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *physician* prefers a specific *hospital* or *physician*.

* 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.

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

Blood Benefits. 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.

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the "Preventive Care Benefits".
2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the "Preventive Care Benefits".
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
5. Breast prostheses following a mastectomy (see "Prosthetic Devices Benefits").

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

Chemotherapy Benefits. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

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

Clinical Trial of Cancer and Other Life Threatening Conditions Benefits. Coverage is provided for routine patient costs you receive as a *member* in an approved clinical trial. The services must be those that are listed as covered by this plan for *members* who are not enrolled in a clinical trial.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by the *plan*.

An “approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

1. Federally funded trials approved or funded by one or more of the following:
 - a. The National Institutes of Health,
 - b. The Centers for Disease Control and Prevention,
 - c. The Agency for Health Care Research and Quality,
 - d. The Centers for Medicare and Medicaid Services,
 - e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
 - g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified *individuals* who have no interest in the outcome of the review:
 - i. The Department of Veterans Affairs,
 - ii. The Department of Defense, or
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your *physician* after determining participation has a meaningful potential to *benefit* you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the *plan's* Clinical Coverage Guidelines, related policies and procedures.

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

1. The investigational item, device, or service.
2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4. Any item, device, or service that is paid for, by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

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

Dental Care Benefits

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* 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, may not be covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *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* unless the chewing or biting results from a medical or mental condition.
4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
5. **Orthognathic Surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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

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

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

2. Diabetes education program which:
 - a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.

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

3. The following items are covered as medical supplies:
 - a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
 - b. Testing strips, lancets, and alcohol swabs.
4. Screenings for gestational diabetes are covered under your "Preventive Care Benefits". Please see that provision for further details.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures Benefits" provision of this section.

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

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

Emergency Room. *Benefits* are provided for *medically necessary* services provided in the emergency room of a hospital.

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

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

No *benefits* will be provided for the following:

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

Hemodialysis Treatment Benefits. This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis facility;
- Home dialysis; and
- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

Home Health Care Benefits. 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*.

Benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home. Please see the "Mental Health Conditions and Substance Abuse" for a description of this coverage.

If your *Plan* has a Calendar Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Calendar Year Deductible has not been met.

Home health care services are subject to pre-service review to determine medical necessity. Please refer to *Medicare* 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 Benefits " provision of this section.

Hospice Care Benefits. 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. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. 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 the *claims administrator*. *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 *member's* or the *dependent'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 the *claims administrator* every 30 days.

Hospital Benefits

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

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

Mental Health Conditions and Substance Abuse Benefits. This *plan* provides coverage for the *medically necessary* treatment of *mental health conditions* and substance abuse. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions, except as specifically stated in this section.

Services for the treatment of *mental health conditions* and substance abuse covered under this *plan* are subject to the same *deductibles* and *copayments* that apply to services provided for other covered medical conditions and prescription drugs.

Covered services shown below for the *medically necessary* treatment of *mental health conditions* and substance abuse, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services and services from a *residential treatment center* (including crisis residential treatment) as stated in the "Hospital" provision of this section, for inpatient services and supplies, and *physician* visits during a covered inpatient *stay*.
2. Outpatient Office Visits for the following:
 - individual and group mental health evaluation and treatment,
 - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
 - drug therapy monitoring,
 - individual and group chemical dependency counseling,
 - medical treatment for withdrawal symptoms,
 - methadone maintenance treatment,
 - Behavioral health treatment for pervasive developmental disorder or autism delivered in an office setting.
- Other Outpatient Items and Services:
 - Partial hospitalization, including intensive outpatient programs and visits to a *day treatment center*. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies,
 - Psychological testing,
 - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
 - Behavioral health treatment for pervasive developmental disorder or autism delivered at home.
3. Behavioral health treatment for pervasive developmental disorder or autism. Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the

services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan* (see *Medicare* for details).

4. Diagnosis and all *medically necessary* treatment of *severe mental disorder* of a person of any age and serious emotional disturbances of a child.

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

Osteoporosis Benefits. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed *medically necessary*.

Phenylketonuria (PKU) Benefits. *Benefits* for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed *physician* and managed by a health care professional in consultation with a *physician* who specializes in the treatment of metabolic disease and who participates in or is authorized by the *plan*. The diet must be deemed *medically necessary* to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a *physician* or nurse practitioner, or ordered by a registered dietician upon referral by a health care *provider* authorized to prescribe dietary treatments, and is *medically necessary* for the treatment of PKU. Formulas and special food products that are not obtained from a pharmacy are covered under *this benefit*.

"Special food product" means a food product that is all of the following:

- Prescribed by a *physician* or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified *physicians* with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

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

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, 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.

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

Prescription Drugs Obtained From Or Administered By a Medical Provider. Your *plan* includes *benefits* for prescription drugs, including specialty drugs, that must be administered to you as part of a *physician* visit, services from a *home health agency*, or at an outpatient *hospital* when they are *covered services*. Refer to *Medicare* for coverage details. This section describes your *benefits* when your *physician* orders the medication and administers it to you.

Benefits for drugs that you inject or get at a retail pharmacy (i.e., self-administered drugs) are not covered under this section. Benefits for those and other covered drugs are described under your *plan's* prescription drug *benefits* (if such *benefits* are included).

Non-duplication of *benefits* applies to pharmacy drugs under this *plan*. When *benefits* are provided for pharmacy drugs under the *plan's* medical *benefits*, they will not be provided under your prescription drug *benefits*, if included. Conversely, if *benefits* are provided for pharmacy drugs under your prescription drug *benefits*, if included, they will not be provided under the *plan's* medical *benefits*.

Preventive Care Benefits. Subject to *Medicare* guidelines, preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law.

Certain *benefits* for *members* who have current symptoms or a diagnosed health problem may be covered under a different *benefit* instead of this benefit, if the coverage does not fall within the state or ACA-recommended *preventive care services*.

1. A *physician's* services for routine physical examinations.
2. Immunizations prescribed by the examining *physician*.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services Benefit".
4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. All FDA-approved contraceptive drugs, devices and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive drugs, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a *physician*, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

In order to be covered as preventive care, contraceptive prescription drugs must be either a generic or single-source brand name drug (those without a generic equivalent). Multi-source brand name drugs (those with a generic equivalent) will be covered as *preventive care services* when *medically necessary* according to your attending *doctor*, otherwise they will be covered under your *plan's* prescription drug benefits (if such *benefits* are included).

8. Preventive services for certain high-risk populations as determined by your *physician*, based on clinical expertise.

This list of *preventive care services* is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no *copayment* and will not apply to the *calendar year deductible*.

See the definition of "*preventive care services*" in the DEFINITIONS starting at page 61, section for more information about services that are covered by this *plan*.

Professional Services Benefit

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

Prosthetic Devices Benefits

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. The *plan* will pay for other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes;
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
 - d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
 - e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient with diabetes.

Radiation Therapy Benefits. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

Reconstructive Surgery Benefits. Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also includes *medically necessary* dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

This does not apply to orthognathic surgery. Please see the “Dental Care Benefits” provision for a description of this service.

Retail Health Clinic Benefits. Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

1. Exams for minor illnesses and injuries.
2. Preventive services and vaccinations.
3. Health condition monitoring and testing.

Skilled Nursing Facility Benefits. Inpatient services and supplies provided by a *skilled nursing facility*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered covered under this *plan*.

Skilled nursing facility services and supplies are subject to pre-service review to determine whether *medically necessary*. Please refer to *Medicare* for information on how to obtain the proper reviews.

Speech Therapy and Speech-language pathology (SLP) Benefits. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment.

Sterilization Benefits. Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.

Certain sterilizations for women are covered under the “Preventive Care Benefits”. Please see that provision for further details.

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

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

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

Travel Immunization Benefits

1. ACA Travel Vaccinations:
 - a. Hepatitis A
 - b. Hepatitis B
 - c. Meningitis
 - d. Polio
2. Other Travel Vaccinations:
 - a. Japanese Encephalitis
 - b. Rabies
 - c. Typhoid
 - d. Yellow Fever

Urgent Care Benefits. Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent

care services are not *emergency services*. Services for urgent care are typically provided by an *urgent care center* or other facility such as a *physician's office*.

Medical Care That Is NOT Covered

No payment will be made under this *plan* for services or supplies that are not *medically necessary* or that were *incurred* before the *member's effective date* or after a *member's* coverage has ended in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

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

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Clinical Trial of Cancer and Other Life Threatening Conditions Benefits" provision under the section Medical Care That Is Covered.

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

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

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

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

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

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care*, rest cures, except as specifically provided under the "Hospice Care Benefits" provision 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 Benefits" provision of Medical Care That Is Covered.

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

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

This exclusion does not apply to the following:

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

Educational or Academic Services. This *plan* does not cover:

1. Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
2. Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.

3. Academic or educational testing.
4. Teaching skills for employment or vocational purposes.
5. Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
6. Teaching manners and etiquette or any other social skills.
7. Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Excess Amounts. Any amounts in excess of *maximum allowed amounts* or any Medical Benefit Maximum.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied *benefits* because it is determined that the requested treatment is *experimental* or *investigative*, you may request [that the denial be reviewed](#).

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

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

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

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

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

Hearing Aids or Tests. Hearing aids, except as specifically stated in the "Hearing Aid Benefits" provision of Medical Care That Is Covered. Routine hearing tests, except as specifically provided as part of a routine exam under the "Preventive Care Benefits" provision of Medical Care That Is Covered.

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

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

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

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

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

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

This exclusion does not apply to the *medically necessary* treatment of specifically stated in “Durable Medical Equipment Benefits” provision of Medical Care That Is Covered.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care *providers* and treatment or services for which the *provider* of services is not required to be licensed. This includes treatment or services from a non-licensed *provider* under the supervision of a licensed *physician*, except as specifically provided or arranged by the *claims administrator*. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined. See page 63 in the DEFINITIONS section for more information.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam under the “Preventive Care Benefits” provision of Medical Care That Is Covered. Eyeglasses or contact lenses, except as specifically stated in the “Prosthetic Devices Benefits” provision of Medical Care That Is Covered.

Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the “Reconstructive Surgery Benefits” or “Dental Care Benefits” provisions of Medical Care That Is Covered.

Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the “Prosthetic Devices Benefits” provision of Medical Care That Is Covered.

Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the “Home Health Care Benefits”, “Hospice Care Benefits” or “Physical Therapy, Physical Medicine and Occupational Therapy Benefits” provisions of that section. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the “Prescription Drug for Abortion Benefits” or “Preventive Care Benefits” provisions of Medical Care That Is Covered. Cosmetics, health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment Benefits” provision of Medical Care That Is Covered, are covered, subject to all terms of this *plan* that apply to that benefit.

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 Benefits”, “Hospice Care Benefits”, or “Physical Therapy, Physical Medicine and Occupational Therapy Benefits” provisions of Medical Care That Is Covered. This exclusion also does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Private Contracts. Services or supplies provided pursuant to a private contract between the *member* and a *provider*, for which reimbursement under the *Medicare* program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act, except for outpatient office visits specifically stated in the “Mental Health Conditions and Substance Abuse Benefits” provision of Medical Care That Is Covered.

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

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital, hospice, skilled nursing facility* or *residential treatment center*.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Preventive Care Benefits" provision 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.

Speech Therapy. Speech therapy except as stated in the "Speech Therapy and Speech language pathology (SLP) Benefits" provision of Medical Care That Is Covered. This exclusion also does not apply the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Sterilization Reversal. Reversal of an elective sterilization.

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

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

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

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

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

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

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

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

Subject to *Medicare* guidelines, this *plan* provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this *plan* are subject to the same *deductibles* and *copayments* that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the “Definitions” below) will be covered under *plan benefits* that apply for outpatient office visits or other outpatient items and services. Services provided in a facility, such as the outpatient department of a *hospital*, will be covered under *plan benefits* that apply to such facilities. See also the “Mental Health Conditions and Substance Abuse Benefits” under Medical Care That Is Covered.

You must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No *benefits* are payable for these services if pre-service review is not obtained.

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

DEFINITIONS

Pervasive Developmental Disorder or autism means one or more of disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
- A person licensed as a *physician* and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Professional is a *provider* who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service *provider* approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior

management consultant, or behavior management program as defined in state regulation or who meets equivalent criteria in the state in which he or she practices if not providing services in California, and

- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice *provider* behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

The behavioral health treatment services covered by this *plan* for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed *physician* and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service *provider*, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - ◆ Describes the patient's behavioral health impairments to be treated,
 - ◆ Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
 - ◆ Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
 - ◆ Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
 - ◆ The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to the *claims administrator* upon request.

SUBROGATION AND REIMBURSEMENT

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

Subrogation

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

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

Reimbursement

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

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

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

Your Duties

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

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

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

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

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

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

The following are not Allowable Expense:

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

Other Plan is any of the following:

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFITS DETERMINATION

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

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

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

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

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

- a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.
- b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that child as a dependent of the parent with custody.
 - ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that child as a dependent of the parent without custody.
 - iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a *dependent* of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a *dependent* of a laid-off or retired employee pays after a plan covering you as other than a laid-off or *retired employee* or the *dependent* of such a person. But if either plan does not have a provision regarding laid-off or *retired employees*, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an *employee*, a *dependent* or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of *benefit* determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Retired Employees and Their Spouses. If you are a *retired employee* or the *spouse* of a *retired employee* and you are eligible for *Medicare* Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS.

Coordinating Benefits With Medicare. The *plan* will not provide benefits that duplicate any benefits to which you would be entitled under *Medicare*. This exclusion applies to all parts of *Medicare* in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of *Medicare*, this exclusion will apply to that part of *Medicare* only if you are enrolled in that part.

If you are entitled to *Medicare*, your *Medicare* coverage will not affect the services covered under this *plan* except as follows:

1. *Medicare* must provide benefits first to any services covered both by *Medicare* and under this *plan*.
2. For services you receive that are covered both by *Medicare* and under this *plan*, coverage under this *plan* will apply only to *Medicare deductibles*, co-insurance, and other charges for *covered services* over and above what *Medicare* pays.
3. For any given claim, the combination of benefits provided by *Medicare* and the benefits provided under this *plan* will not exceed the *maximum allowed amount* for the *covered services*.

The *claims administrator* will apply any charges paid by *Medicare* for services covered under this *plan* toward your *plan deductible*, if any.

UTILIZATION REVIEW PROGRAM

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

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

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

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

1. You must be eligible for *benefits*;
2. The service or supply must be a *covered service* under your *plan*;
3. The service cannot be subject to an exclusion under your *plan* (please see Medical Care That Is Covered for more information); and
4. You must not have exceeded any applicable limits under your *plan*.

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

You and your *physician* will be advised if it is determined that the stay is not *medically necessary*. If services are certified as not *medically necessary*, but you nevertheless choose to receive those services, you are responsible for all charges not reimbursed by the *plan*.

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

ELIGIBILITY, ENROLLMENT AND TERMINATION PROVISIONS

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

Employees

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

Retirees

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

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

Qualified Beneficiary means a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either a *member* or enrolled *spouse* or *domestic partner*. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *spouse* or *domestic partner* acquired during the COBRA continuation period.

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

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

ELIGIBILITY FOR COBRA CONTINUATION

A *member* or enrolled *spouse* or *domestic partner* may choose to continue coverage under the *plan* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *plan administrator* will notify either the *member* or *spouse* or *domestic partner* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, the *plan administrator* will notify the *member* of the right to continue coverage.
2. For Qualifying Events 2(b) or 2(c) above, a *spouse* or *domestic partner* will be notified of the COBRA continuation right.
3. You must inform the *plan administrator* within 60 days of Qualifying Events 2(b) or 2(c) above, if you wish to continue coverage. The *plan administrator*, in turn, will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *plan administrator* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for both *family members*, or for the *member* only, or for the *spouse* only.

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

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

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

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

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *member*;
2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *member*;

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

For *spouse* or *domestic partner* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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

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

*For a *member* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*.

Subject to the *plan* remaining in effect, a retired *member* whose COBRA continuation coverage began due to Qualifying Event 1 may be covered for the remainder of his or her life; that person's covered *spouse* or *domestic partner* may continue coverage for 36 months after the *member's* death. However, coverage could terminate prior to such time for either *member* or *dependent* in accordance with any of the items above.

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

GENERAL PROVISIONS

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

Independent Contractors. The *claims administrator's* relationship with *providers* is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor are they, or any of their employees, an employee or agent of any *hospital*, medical group or medical care *provider* of any type.

Non-Regulation of Providers. The *benefits* of this *plan* do not regulate the amounts charged by *providers* of medical care.

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

- The billed charges for *covered services*; or
- The negotiated price that the Host Blue makes available to *us*.

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When *covered services* are provided outside of Anthem Blue Cross’s Service Area by non-participating *providers*, we may determine *benefits* and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as a *deductible* or *copayment* will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating *provider* bills and the payment we will make for the *covered services* as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network *emergency services*.

2. Exceptions

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

F. Blue Cross Blue Shield Global Core ® Program

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

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

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

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

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

- *Physician* services;
- Inpatient *hospital* care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

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

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

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

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

Terms of Coverage

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

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

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

Medical Necessity. The *benefits* of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

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

Benefits Not Transferable. Only the *member* is entitled to receive *benefits* under this *plan*. The right to *benefits* cannot be transferred.

Notice of Claim. You must send the *claims administrator* 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. The *plan administrator* is not liable for the *benefits* of the *plan* if you do not file claims within the required time period. The *plan administrator* will not be liable for *benefits* if the *claims administrator* does 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.

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

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

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

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

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

Under certain circumstances, if the *claims administrator* pays your healthcare *provider* amounts that are your responsibility, such as *deductibles* or *copayments*, the *claims administrator* may collect such amounts directly from you. You agree that the *claims administrator* has the right to recover such amounts from you.

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

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

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

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

Prepayment Fees. The *plan administrator* may require that you contribute all or part of the costs of these required monthly contributions. Please consult your *plan administrator* for details.

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

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

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

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

Voluntary Wellness Incentive Programs. The *claims administrator* may offer health or fitness related program options for purchase by the *plan administrator* to help you achieve your best health. These

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

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

Plan Notice of Privacy Practices for Claims Administrator *

Notice of Privacy Practices

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

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

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

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

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

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

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

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

***Business Associate to the UC Medicare PPO**

Notice of Privacy Practice for Plan

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

BINDING ARBITRATION

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

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

The *member* and the *plan administrator* 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 the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the *member* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* 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 the *plan administrator*. 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 the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree that has completed the internal appeals process.

DEFINITIONS

The meanings of key terms used in this booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this booklet, 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.

Benefit is a *benefit* provided to eligible *members* under the *plan* consistent with any terms and conditions stated in the *plan*.

Benefit booklet (benefit booklet) is this written description of the *benefits* provided under the *plan*.

Benefit period, as defined by *Medicare* for inpatient *hospital* and *skilled nursing facility* services (Part A), begins when you first enter a *hospital* after your *Medicare* insurance begins. In no event will a new *benefit period* start until you have been discharged and have remained out of the *hospital* or other facility as an inpatient for at least 60 consecutive days. For medical services (Part B), *benefit period* is defined as a *calendar year*.

Chiropractic services means *medically necessary* care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.)

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

Copayment is the dollar amount or percentage of the *maximum allowed amount* unless otherwise specified that a *member* is required to pay for specific *covered services* after meeting any applicable *deductible*. See page 19 under Medical Benefit Summary Notes section.

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

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

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

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

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

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental health conditions* or substance abuse under the supervision of *physicians*.

Deductible is the *calendar year* amount which you must pay for specific *covered services* that are a *benefit* of the *plan* before you become entitled to receive *benefit* payments from the *plan* for those services. See page 19 under Medical Benefit Summary Notes section.

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

Domestic partner as defined in the “Eligible Family Members” section of the “Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members”. A copy of this factsheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

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

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

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

Employee is an individual who meets the eligibility requirements established by the Employer and accepted by the *claims administrator*.

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

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

Family member is the *member* and all enrolled *dependents*.

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

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

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient *hospital* care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general *hospital* by the American Hospital

Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care, the definition of *hospital* also includes: (1) *psychiatric health facilities* (only for the acute phase of a *mental health conditions* or substance abuse), and (2) *residential treatment centers*.

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

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

Intensive in-home behavioral health program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a *mental health conditions* or substance abuse, put the *members* and others at risk of harm.

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

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

Maximum allowed amount is the maximum amount of reimbursement the *claims administrator* will allow for covered medical services and supplies under this *plan*. See YOUR MEDICAL BENEFITS - MAXIMUM ALLOWED AMOUNT.

Medically necessary procedures, supplies equipment or services are those the *claims administrator* determines to be:

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

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

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

Medicare eligible expenses are expenses of the kinds covered by *Medicare* Part A and B to the extent recognized as reasonable and *medically necessary* by *Medicare*.

Member/Individual is the *employee, spouse, or dependent* covered by the *plan*.

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

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*; or
11. A retail pharmacy.

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

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

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following *providers*, but only when the *provider* is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which *benefits* are specified in this booklet:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A licensed educational psychologist or other *provider* permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.)
 - A licensed clinical social worker (L.C.S.W.)
 - A marriage and family therapist (M.F.T.)
 - A licensed professional clinical counselor (L.P.C.C.)*
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*
 - An audiologist*

- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse midwife**
- A nurse practitioner
- A *physician* assistant
- A *psychiatric mental health nurse* (R.N.)*
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.
- A qualified autism service *provider*, qualified autism service professional, and a qualified autism service paraprofessional, as described under the BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM section.

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

Plan is the University of California Supplement to *Medicare* for eligible retired employees and dependents of the *employer*.

Plan administrator is The Regents of The University of California.

Plan sponsor is The Regents of the University of California.

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

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

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

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

<http://www.ahrq.gov>

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

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

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

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

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

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

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

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

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

Residential treatment center is a *provider* licensed and operated as required by law, which includes:

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

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

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

- Educational care

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

Retired employee as defined in the “Eligible Family Members” section of the “Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members”. A copy of this factsheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

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

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

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

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

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

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

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

Totally disabled dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

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

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

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

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

We (us, our) refers to The Regents of the University of California.

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

You (your) refers to the *member* and *dependents* who are enrolled for *benefits* under this *plan*.

YOUR RIGHT TO APPEALS

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

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

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

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

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

Notice of Adverse Benefit Determination

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

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

For claims involving urgent/concurrent care:

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

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The *claims administrator's* review of your claim will take into account

all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

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

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

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

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

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

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

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

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

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

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

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

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

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

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

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

Requirement to file an Appeal before taking further legal action

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

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

FOR YOUR INFORMATION

Anthem Blue Cross Web Site

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

Identity Protection Services

The *claims administrator* has made identity protection services available to *members*. To learn more about these services, please visit www.anthem.com/resources.

Language Assistance Program

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

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

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

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

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والخدمات وللمساعدة بلغتك مجاناً. اتصل بخدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمک‌ها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک‌ها به شماره مرکز خدمات اعضا تماس بگیرید. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលបានជំនួយ។(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY