Prudent Buyer Plan
Benefit Booklet

January 1, 2015

UNIVERSITY OF SAN FRANCISCO
CHANGE THE WORLD FROM HERE

SPD00020-1 0315 Mod. P3 (PB 250-20/90/70) Contract Code AC97
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.
Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
Dear Plan Member:

This Benefit Booklet provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Subscribers and covered dependents ("beneficiaries") are referred to in this booklet as "you" and "your". The plan administrator is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Benefit Booklet ("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: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto 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).
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TYPES OF PROVIDERS

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

Participating Providers in California. The plan has made available to the beneficiaries a network of various types of “Participating Providers”. These providers are called “participating” because they have agreed to participate in the claims administrator’s preferred provider organization program (PPO), called the Prudent Buyer Plan. Participating providers have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this plan will be different for non-participating providers than for participating providers. See the definition of “Participating Providers” in the DEFINITIONS section for a complete list of the types of providers which may be participating providers.

We will provide you with a directory of participating providers upon request. The directory lists all participating providers in your area, including health care facilities such as hospitals and skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers. You may call the claims administrator at the customer service number listed on your ID card and ask the claims administrator to send you a directory. You may also search for a participating provider using the “Provider Finder” function on the claims administrator’s website at www.anthem.com/ca.

How to Access Primary and Specialty Care Services

Your health plan covers care provided by primary care physicians and specialty care providers. To see a primary care physician, simply visit any participating provider physician who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any participating provider specialty care provider you choose (certain providers’ services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy), see “Physician,” below). Referrals are never needed to visit any participating provider specialty care provider including a behavioral health care provider.

To make an appointment call your physician’s office:

- Tell them you are a Prudent Buyer Plan member.
• Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.

• Tell them the reason for your visit.

When you go for your appointment, bring your Member ID card.

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how 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.

Participating Providers Outside of California

If you are outside of the California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a participating provider in the area you are in. A directory of PPO Providers outside of California is available upon request.

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

The claims administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from non-participating providers could be balance billed by the non-participating provider for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider’s failure to submit medical records with the claims that are under review in these processes.

Contracting and Non-Contracting Hospitals. Another type of provider is the "contracting hospital". This is different from a hospital which is a participating provider. The claims administrator has contracted with most hospitals in California to obtain certain advantages for patients covered under the plan. While only some hospitals are participating providers, all eligible California hospitals are invited to be contracting hospitals and most--over 90%--accept. For those which do not (called non-contracting hospitals), there is a significant benefit penalty in your plan.
Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the plan. This doesn't mean they can provide every service that a medical doctor could; it just means that the plan will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as physicians. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

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

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

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the prescription drug maximum allowed amount to fill the prescription. You pay only your co-payment amount.

"Non-Participating Pharmacies" have not agreed to the prescription drug maximum allowed amount. The amount that will be covered as prescription drug covered expense is significantly lower than what these providers customarily charge.
Centers of Medical Excellence. The claims administrator is providing access to the following separate Centers of Medical Excellence (CME) networks. The facilities included in each of these CME networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, CME have agreed to a rate they will accept as payment in full for covered services. **These procedures are covered only when performed at a CME.**

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a CME.**

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

Care Outside the United States—BlueCard Worldwide

Prior to travel outside the United States, call the customer service telephone number listed on your ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the customer service number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with urgent care or an emergency when travelling outside the United States.**

- Always carry your current ID card.

- In an emergency, seek medical treatment immediately.

- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.
Payment Information

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The hospital should submit your claim on your behalf.

- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a physician, and inpatient care from a hospital that is not a participating BlueCard Worldwide hospital. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- **Participating BlueCard Worldwide hospitals will file your claim on your behalf.** You will have to pay the hospital for the out-of-pocket costs you normally pay.

- **You must file the claim** for outpatient and physician care, or inpatient hospital care not provided by a participating BlueCard Worldwide hospital. You will need to pay the health care provider directly and subsequently send an international claim form with the original bills to the claims administrator in order to be reimbursed.

Additional Information About BlueCard Worldwide Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.

- Exchange rates are determined as follows:
  - For inpatient hospital care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

- International claim forms are available from the claims administrator, from the BlueCard Worldwide Service Center, or online at:
  
  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.
SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED TO BE MEDICALLY NECESSARY AS DEFINED IN THE BENEFIT BOOKLET. 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 BOOKLET OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD 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. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire benefit booklet for more complete information about the benefits, conditions, limitations and exclusions of your plan.

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

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.

Telehealth. This plan provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the plan. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. “Telehealth” is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient’s health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

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

The benefits of this plan are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles
- Individual Deductible ................................................................. $250
- Family Deductible ................................................................. $750

Additional Deductibles*
- Emergency Room Deductible ....................................................... $50
- Non-Certification Deductible ....................................................... $250

*Please note these deductibles do not accrue toward the satisfaction of the Calendar Year Deductibles.

Exceptions: In certain circumstances, one or more of these deductibles may not apply, as described below:

- The Calendar Year Deductible will not apply to benefits for Preventive Care Services provided by a participating provider.
- The Calendar Year Deductible will not apply to hospice care services provided by a physician who is a participating provider.
- The Calendar Year Deductible will not apply to office visits to a physician who is a participating provider.

Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

- The Calendar Year Deductible will not apply to diabetes education program services provided by a physician who is a participating provider.
- The Calendar Year Deductible will not apply to chiropractic services provided by a physician who is a participating provider.
- The Calendar Year Deductible will not apply to acupuncture services provided by a physician who is a participating provider.
- The Calendar Year Deductible will not apply to transplant travel expenses authorized by the claims administrator in connection with a specified transplant procedure provided at a designated CME.
– The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated CME.

– The Emergency Room Deductible will not apply if you are admitted as a hospital inpatient immediately following emergency room treatment.

– The Non-Certification Deductible will not apply to emergency admissions or services, services provided by a participating provider, or to medically necessary inpatient facility services available to you through the BlueCard Program. See UTILIZATION REVIEW PROGRAMS.

– The Additional Deductibles will not apply for the remainder of the year once your Out-of-Pocket Amount is reached.

CO-PAYMENTS

First Level of Co-Payments.* After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for the following percentages of the maximum allowed amount:

- Participating Providers .......................................................... 10%
- Other Health Care Providers .................................................. 20%
- Non-Participating Providers ................................................... 30%

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

*Exceptions:

– There will be no Co-Payment for any covered services provided by a participating provider under the Preventive Care benefit.

– There will be no Co-Payment for any covered services provided by a participating provider under the Hospice Services benefit.
Your Co-Payment for non-participating providers for emergency services will be 10% of billed charges (physician and institutional charges). Please note that you will be responsible for the balance of billed charges which exceed the maximum allowed amount.

Your Co-Payment for non-participating providers will be the same as for participating providers for the following services. You will be responsible for charges which exceed the maximum allowed amount.

a. An authorized referral from a physician who is a participating provider to a non-participating provider (see UTILIZATION REVIEW PROGRAM);

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

c. Cancer Clinical Trials.

Your Co-Payment for office visits to a physician who is a participating provider will be $20. This Co-Payment will not apply toward the satisfaction of any deductible.

Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

Your Co-Payment for diabetes education program services provided by a physician who is a participating provider will be $20. This Co-Payment will not apply toward the satisfaction of any deductible.

Your Co-Payment for chiropractic services provided by a physician who is a participating provider will be $20. Your Co-Payment will not apply toward the satisfaction of any deductible.

Your Co-Payment for acupuncture services provided by a physician who is a participating provider will be $20. Your Co-Payment will not apply toward satisfaction of any deductible.

Your Co-Payment for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) authorized by the claims administrator and performed at a designated CME will be the same as for participating providers. Services for specified organ transplants are not covered when performed at other than a designated CME. See UTILIZATION REVIEW PROGRAM.
- **NOTE:** No Co-Payment will be required for the transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant performed at a designated *CME*. Transplant travel expense coverage is available when the closest *CME* is 75 miles or more from the recipient’s or donor’s residence.

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

- **NOTE:** Co-Payments do not apply to bariatric travel expenses authorized by the *claims administrator*. Bariatric travel expense coverage is available when the closest *CME* is 50 miles or more from the *member’s residence*. 
Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for covered charges incurred during a calendar year, you will no longer be required to pay a Co-Payment for the remainder of that year, but you remain responsible for costs in excess of the maximum allowed amount and the prescription drug maximum allowed amount.

- Per member.................................................................$ 899
- Per family$.................................................................2,667

Non-Contracting Hospital Penalty. The maximum allowed amount is reduced by 25% for services and supplies provided by a non-contracting hospital. This penalty will be deducted from the maximum allowed amount prior to calculating your Co-Payment amount, and any benefit payment by us will be based on such reduced maximum allowed amount. You are responsible for paying this extra expense. This reduction will be waived only for emergency services. To avoid this penalty, be sure to choose a contracting hospital.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility
- For covered skilled nursing facility care..............................100 days per calendar year

Home Health Care
- For covered home health services.................................120 visits per 12-month period

Home Infusion Therapy
- For all covered services and supplies received during any one day.........................................................$600*
  *Non-participating providers only

Ambulatory Surgical Center
- For all covered services and supplies...............................$350*
  *Non-participating providers only
Outpatient Hemodialysis
- For all covered services and supplies............................................$350* per visit
  *Non-participating providers only

Advanced Imaging Procedures
- For all covered services............................................................$800* per procedure
  *Non-participating providers only

Ambulance
- For air ambulance transportation that is not related to an emergency ...........................................$50,000* per trip
  *Non-participating providers only

Chiropractic Services
- For covered outpatient services..............................................30 visits per calendar year,
  additional visits as authorized if medically necessary

Acupuncture
- For all covered services...........................................................20 visits per calendar year

Transplant Travel Expense
- For all authorized travel expense in connection with a specified transplant performed at a designated CME .........................$10,000 per transplant

Unrelated Donor Searches
- For all charges for unrelated donor searches for covered bone marrow/stem cell transplants .........................$30,000 per transplant
Bariatric Travel Expense

- For all authorized travel expenses
  in connection with a specified bariatric surgery
  performed at a designated CME...................... up to $3,000
  per surgery

Lifetime Maximum

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

PRESCRIPTION DRUG BENEFITS

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

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

Participating Pharmacies

- **Generic Drugs**................................. $10

- **Brand Name Drugs:**
  - Formulary drugs ........................................ $20
  - Non-formulary drugs............................... $25

- **Compound medications**.......................... $25

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

Non-Participating Pharmacies*

- **Generic Drugs**................................................. $10
plus 50% of the remaining prescription drug maximum allowed amount

• **Brand Name Drugs:**
  - Formulary drugs ................................................................. $20  
    plus 50% of the remaining prescription drug maximum allowed amount
  - Non-formulary drugs ......................................................... $25  
    plus 50% of the remaining prescription drug maximum allowed amount

**Home Delivery Prescriptions.** The following co-payments apply for a 90-day supply of medication.

• **Generic Drugs** ................................................................. $10

• **Brand Name Drugs:**
  - Formulary drugs ................................................................. $20
  - Non-formulary drugs ......................................................... $25

**Exception to Prescription Drug Co-payments**

• “Preventive Prescription Drugs and Other Items” covered under YOUR PRESCRIPTION DRUG BENEFITS ................................................................. No charge

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

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

**Note:** If your pharmacy’s retail price for a *drug* is less than the co-payment shown above, you will not be required to pay more than that retail price.
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 from participating and non-participating providers. It is the claims administrator’s payment towards the services billed by your provider combined with any Deductible or Co-Payment 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 Deductible under this plan, then you could be responsible for paying the entire maximum allowed amount for covered services. In addition, if these services are received from a non-participating provider, you may be billed by the provider for the difference between their charges and the maximum allowed amount. In many situations, this difference could be significant.

Provided below are two examples below, which illustrate how the maximum allowed amount works. These examples are for illustration purposes only.

Example: The plan has a member Co-Payment of 10% for participating provider services after the Deductible has been met.

- The member receives services from a participating surgeon. The charge is $2,000. The maximum allowed amount under the plan for the surgery is $1,000. The member’s Co-Payment responsibility when a participating surgeon is used is 10% of $1,000, or $100. This is what the member pays. The plan pays 90% of $1,000, or $900. The participating surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a member Co-Payment of 30% for non-participating provider services after the Deductible has been met.

- The member receives services from a non-participating surgeon. The charge is $2,000. The maximum allowed amount under the plan for the surgery is $1,000. The member’s Co-Payment responsibility when a non-participating surgeon is used is 30% of $1,000, or $300. The plan pays the remaining 70% of $1,000, or $700. In addition, the non-participating surgeon could bill the member the difference between $2,000 and $1,000. So the member’s total out-of-pocket charge would be $300 plus an additional $1,000, for a total of $1,300.
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 provider 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.

Provider Network Status

The maximum allowed amount may vary depending upon whether the provider is a participating provider, a non-participating provider or other health care provider.

Participating Providers and CME. For covered services performed by a participating provider or CME the maximum allowed amount for this plan will be the rate the participating provider or CME has agreed with the claims administrator to accept as reimbursement for the covered services. Because participating providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your Deductible or have a Co-Payment. Please call the customer service telephone number on your ID card for help in finding a participating provider or visit www.anthem.com/ca.

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

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

Non-Participating Providers and Other Health Care Providers.*
Providers who are not in our Prudent Buyer network are non-participating providers or other health care providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from a non-participating provider or other health care provider the maximum allowed amount will be based on the applicable non-participating provider 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 non-participating provider, an amount derived from the total charges billed by the non-participating provider, or 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 not contracted for this product, but are contracted for other products, are also considered non-participating providers. For this plan, the maximum allowed amount for services from these providers will be one of the methods shown above unless the provider’s contract specifies a different amount.

Unlike participating providers, non-participating providers and other health care providers may send you a bill and collect for the amount of the non-participating provider’s or other health care provider’s charge that exceeds the maximum allowed amount under this plan. You may be responsible for paying the difference between the maximum allowed amount and the amount the non-participating provider or other health care provider charges. This amount can be significant. Choosing a participating provider will likely result in lower out of pocket costs to you. Please call the customer service number on your ID card for help in finding a participating provider or visit the website www.anthem.com/ca. Customer service is also available to assist you in determining this plan’s maximum allowed amount for a particular covered service from a non-participating provider or other health care provider.

Please see the “Out Of Area Services” provision in the section entitled GENERAL PROVISIONS for additional information.

*Exceptions:

– Cancer Clinical Trials. The maximum allowed amount for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating provider.
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** who is a **participating provider** who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

3. By a **physician** who is a **non-participating provider** or **other health care provider** who accepts Medicare assignment, in excess of the lesser of **maximum allowed amount** stated above, or the approved amount as determined by Medicare; or

4. By a **physician or other health care provider** who does not accept Medicare assignment, in excess of the lesser of the **maximum allowed amount** stated above, or the limiting charge as determined by Medicare.

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

**MEMBER COST SHARE**

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the **maximum allowed amount** as your cost share amount (Deductibles or Co-Payments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received covered services from a **participating provider** or **non-participating provider**. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using **non-participating providers**. Please see the **SUMMARY OF BENEFITS** section for your cost share responsibilities and limitations, or call the customer service telephone number on your ID card to learn how this plan’s benefits or cost share amount may vary by the type of provider you use.

The **claims administrator** will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a **participating provider** or **non-participating provider**. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances you may only be asked to pay the lower **participating provider** cost share percentage when you use a **non-participating provider**.
For example, if you go to a participating hospital or facility and receive covered services from a non-participating provider such as a radiologist, anesthesiologist or pathologist providing services at the hospital or facility, you will pay the participating provider cost share percentage of the maximum allowed amount for those covered services. However, you also may be liable for the difference between the maximum allowed amount and the non-participating provider’s charge.

AUTHORIZED REFERRALS

In some circumstances the claims administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the claims administrator in advance of obtaining the covered service. It is your responsibility to ensure that the claims administrator has been contacted. If the claims administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider’s charge. Please call the customer service telephone number on your ID card for authorized referral information or to request authorization.

WARNING! Reduction of The Maximum Allowed amount for Non-Contracting Hospitals. A small percentage of hospitals which are non-participating providers are also non-contracting hospitals. Except for emergency care, the maximum allowed amount is reduced by 25% for all services and supplies provided by a non-contracting hospital. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a contracting hospital. You can call the customer service number on your identification card to locate a contracting hospital.

DEDUCTIBLES, CO-PAYMENTS AND MEDICAL BENEFIT MAXIMUMS
(Refer to Summary of Benefits on Page 6)

After subtracting any applicable deductible and your Co-Payment, the plan will pay benefits up to the maximum allowed amount, not to exceed any applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.
DEDUCTIBLES

Each deductible under this plan is separate and distinct from the other. Only the covered charges that make up the maximum allowed amount will apply toward the satisfaction of any deductible, except as specifically indicated in this booklet.

Calendar Year Deductibles. Each year, you will be responsible for satisfying the individual's Calendar Year Deductible before we begin to pay benefits. If individuals of an enrolled family pay deductible expense in a year equal to the Family Deductible amount shown in the SUMMARY OF BENEFITS, the Calendar Year Deductible for all individuals of an enrolled family will be considered to have been met.

Covered charges incurred from October through December and applied toward the Calendar Year Deductible for that year also count toward the Calendar Year Deductible for the next year.

Additional Deductibles

1. Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible of $50. But this deductible will not apply if you are admitted as a hospital inpatient from the emergency room immediately following emergency room treatment.

2. Each time you are admitted to a hospital or residential treatment center which is a non-participating provider, you are responsible for paying the Inpatient Deductible of $500. This deductible will not apply to an emergency admission.

3. Each time you are admitted to a hospital or residential treatment center or have outpatient surgery at an ambulatory surgical center without properly obtaining certification, you are responsible for paying the Non-Certification Deductible of $250. This deductible will not apply to an emergency admission or procedure, services provided at a participating provider, or to medically necessary inpatient facility services available to you through the BlueCard Program. Certification is explained in UTILIZATION REVIEW PROGRAM.

Note: You will no longer be responsible for paying any Additional Deductibles for the remainder of the year once your Out-of-Pocket Amount is reached (see the SUMMARY OF BENEFITS section for details).

CO-PAYMENTS

After you have satisfied any applicable deductible, your Co-Payment will be subtracted from the remaining maximum allowed amount.
If your Co-Payment is a percentage, the plan will apply the applicable percentage to the maximum allowed amount remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

**MEDICAL BENEFIT MAXIMUMS**

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

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

**Urgent Care.** 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. Urgent care can be obtained from participating providers or non-participating providers.

*When obtaining Urgent Care from a non-participating provider or facility, you may be subject to balance billing and higher out-of-pocket costs.

**Hospital**

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 with 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 medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

**Skilled Nursing Facility.** Inpatient services and supplies provided by a skilled nursing facility, for up to 100 days per calendar year. The amount by which your room charge exceeds the prevailing two-bed room rate of the skilled nursing facility is not covered under this plan.

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.
Home Health Care. The following services provided by a home health agency:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. Medically necessary supplies provided by the home health agency.

In no event will benefits exceed 120 visits per 12-month period. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to prior authorization to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

Hospice Care. The services and supplies listed below are covered when provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. 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 us. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

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

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

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

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

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

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

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the subscriber’s or the 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.

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

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

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services such as those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

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

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

Our maximum payment will not exceed $600 for the services or supplies received during any one day when provided by a home infusion therapy provider which is not a participating provider.

*Home infusion therapy provider* services are subject to prior authorization to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

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

For the services of a non-participating provider facility only, our maximum payment is limited to $350 each time you have outpatient surgery at an ambulatory surgical center.

*Ambulatory surgical center* services are subject to pre-service review to determine medical necessity. If the required pre-service review is not performed, the services received will be subject to the Non-Certification Deductible of $250. If you are seeking services from a non-participating provider, it is your responsibility to ensure this process is completed prior to the service being rendered.

**Retail Health Clinic.** 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.

**Online Care Services.** When available in your area, covered services will include medical consultations using the internet via webcam, chat, or voice. Online care services are covered under plan benefits for office visits to physicians.

Non-covered services include, but are not limited to, the following:

- Reporting normal lab or other test results.
• Office visit appointment requests or changes.
• Billing, insurance coverage, or payment questions.
• Requests for referrals to other physicians or healthcare practitioners.
• Benefit precertification.
• Consultations between physicians.
• Consultations provided by telephone, electronic mail, or facsimile machines.

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

Professional Services

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

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

Ambulance. 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.

The plan’s maximum payment will not exceed $50,000 per trip for air ambulance transportation that is not related to an emergency when performed by a non-participating provider.

Ambulance services are subject to medical necessity reviews. 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.

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 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.

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

Advanced Imaging Procedures. 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 are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

* Advanced imaging procedures, when performed by a non-participating provider, will have a maximum benefit of $800 per procedure.

Radiation Therapy

Chemotherapy
Hemodialysis Treatment. Treatment provided by a freestanding outpatient hemodialysis center which is a non-participating provider is limited to $350 per visit.

Prosthetic Devices

1. Breast prostheses following a mastectomy.

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

3. 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.

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

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

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

The claims administrator will determine whether the item satisfies the conditions above.

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

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

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

3. **Dental Injury.** Services of a physician (M.D.) or dentist (D.D.S.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by 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.

**Important:** If you decide to receive dental services that are not covered under this plan, a participating provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call the customer service telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this benefit booklet document.

**Pregnancy and Maternity Care**

1. All medical benefits for an enrolled member when provided for pregnancy or maternity care, including the following services:
   a. Prenatal and postnatal care;
b. Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other medically necessary maternity services performed outside of a hospital);

c. Involuntary complications of pregnancy;

d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and

e. Inpatient hospital care including labor and delivery.

Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

2. Medical hospital benefits for routine nursery care of a newborn child, if the child’s natural mother is an enrolled member. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

3. Certain services are covered under the “Preventive Care Services” benefit. Please see that provision for further details.

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

1. The recipient; or

2. The donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered members under this plan, each will get benefits under their plans.

- When the person getting the organ is a covered member under this plan, but the person donating the organ is not, benefits under this plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If a member covered under this plan is donating the organ to someone who is not a covered member, benefits are not available under this plan.
The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The plan’s payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed $30,000 per transplant.

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

To maximize your benefits, you should call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. The claims administrator will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Centers of Medical Excellence (CME) rules, or exclusions apply. Call the customer service phone number on the back of your ID card and ask for the transplant coordinator.

You or your physician must call the Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before benefits for a transplant will be provided. Your physician must certify, and the claims administrator must agree, that the transplant is medically necessary. Your physician should send a written request for prior authorization to the claims administrator as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your physician may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or harvest and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.
Specified Transplants

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

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by the claims administrator in advance. The plan’s maximum payment will not exceed $10,000 per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's residence
- Lodging, limited to one room, double occupancy
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

*Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

The Calendar Year Deductible will not apply and no co-payments will be required for transplant travel expenses authorized in advance by the claims administrator. The plan will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.
Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling the customer service number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

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

**Bariatric Travel Expense.** Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated CME that is fifty (50) miles or more from the member’s place of residence, are covered, provided the expenses are authorized by the claims administrator in advance. The fifty (50) mile radius around the CME will be determined by the bariatric CME coverage area (See DEFINITIONS). The plan’s maximum payment will not exceed $3,000 per surgery for the following travel expenses incurred by the member and/or one companion:

- Transportation for the member and/or one companion to and from the CME.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the “Bariatric Travel Expense” benefit is available in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

**Transgender Services.** 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).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. 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.

Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery, when the hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. Our maximum payment will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one companion:

- Ground transportation to and from the hospital when it is 75 miles or more from your place of residence.
- Coach airfare to and from the hospital when it is 300 miles or more from your residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

The Calendar Year Deductible will not apply and no co-payments will be required for transgender travel expenses authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.
Details regarding reimbursement can be obtained by calling the customer service number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

**Mental or Nervous Disorders or Substance Abuse.** Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" provision of this section, for inpatient services and supplies.

2. 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.


4. *Physician* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

5. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVERSIVE 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 UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

**Preventive Care Services.** Screening services, and supplies, provided in connection with *preventive care services* as shown below. The *calendar year* deductible will not apply to these services or supplies when they are provided by a *participating provider*. No co-payment will apply to these services or supplies when they are provided by a *participating provider*.

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”.

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.

   *This includes approved generic and single source brand drugs used for smoking cessation under the Preventive Rx program.

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 methods for women, including over-the-counter items, if prescribed by a physician. In order to be covered as preventive care, contraceptive prescription drugs must be either a generic or single-source brand name drug. Also covered are sterilization procedures and counseling.

   b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

   c. Gestational diabetes screening.

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 section for more information about services that are covered by this plan as preventive care services.

You may call Customer Service using the number on your ID card for additional information about these services. You may also view the federal government's web sites:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

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

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

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

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

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

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

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”).

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

1. Routine and diagnostic mammogram examinations.
2. 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 Services benefit.

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

4. Reconstructive surgery performed to restore and achieve symmetry following a medically necessary mastectomy.

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

Clinical Trials. Coverage is provided for services and supplies for routine patient costs you receive as a participant 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.

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.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an investigative service as defined by the plan (see the DEFINITIONS section).

Participation in the clinical trial must be recommended by your physician after determining participation has a meaningful potential to benefit you.

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

1. The investigational item, device, or service itself.

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, or should have been paid for, by the sponsor of the trial.

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

Physical Therapy, Physical Medicine and Occupational Therapy.
The following services provided by a physician under a treatment plan which offers a reasonable expectation of significant improvement:

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

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

For chiropractic services, up to 30 visits in a year are payable if medically necessary. If additional visits are needed after receiving 30 visits in a year, pre-service review must be obtained prior to receiving the services.

If it is determined that an additional period of chiropractic services is medically necessary, the claims administrator will specify a specific number of additional visits. Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for medically necessary physical therapy, physical medicine, occupational therapy and chiropractic services. But additional visits in excess of the number of visits stated above must be authorized in advance.

If covered charges is applied toward the Calendar Year Deductible and payment is not provided, that visit will be included in the visit maximum (30 visits) for that year.

If you receive chiropractic services from a non-participating provider and you need to submit a claim to the claims administrator, please send it to the address listed below. If you have any questions or are in need of assistance, please call us at the customer service telephone number listed on your ID card.

American Specialty Health
P.O. Box 509001
San Diego, CA 92150-9002

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

- Injectable drugs and implants for birth control, administered in a physician's office, if medically necessary.
• Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a physician if medically necessary.

• Professional services of a physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your physician determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your physician.

**Outpatient Speech Therapy.** Outpatient speech therapy following injury or organic disease.

**Acupuncture.** The services of a physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 12 visits during a calendar year.

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

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

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

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

c. Is supervised by a physician.

Diabetes education services are covered under your plan’s benefits for office visits to physicians.

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


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

c. Testing strips, lancets, and alcohol swabs.

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

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

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

MEDICAL CARE THAT IS NOT COVERED

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

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.
Experimental or Investigative. Any experimental or investigative procedure or medication.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

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

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

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

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

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

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

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

Services of Providers:

1. performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;  
3. performed by a provider with your same legal residence;  
4. ordered or delivered by a Christian Science Practitioner;  
5. performed by an unlicensed provider or a provider who is operating outside the scope of his/her license;  
6. provided by foreign language and sign language interpreters  
7. provided at diagnostic facility (hospital or free-standing) without a written order from a provider;  
8. which are self-directed to a free standing or hospital-based diagnostic facility; and  
9. ordered by a provider affiliated with a diagnostic facility (hospital or free standing), when that provider is not actively involved in your medical care:  
   - Prior to ordering the service; or  
   - After the services is received.  

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.  

Not Specifically Listed. Services not specifically listed in this plan as covered services.
**Private Contracts.** Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

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

**Nicotine Use.** Smoking cessation programs or treatment of nicotine or tobacco use if the program is not affiliated with the *claims administrator*. Smoking cessation *drugs*, except as specifically stated under YOUR PRESCRIPTION DRUG BENEFITS section of this *benefit booklet*.

**Orthodontia.** Braces and other orthodontic appliances or services.

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

**Hearing Aids or Tests.** Hearing aids, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as specifically provided under "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

**Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam under the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

**Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a *home health agency*, *hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", *"Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. 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 PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.
Outpatient Speech Therapy. Outpatient speech therapy except as stated in the “Outpatient Speech Therapy” provision of MEDICAL CARE THAT IS COVERED. 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 PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement. This exclusion does not apply to members who suffer hair loss as a result of chemotherapy or radiation therapy for the treatment of cancer.

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

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 is covered as stated in the “Bariatric Surgery” provision of MEDICAL CARE THAT IS COVERED.

Transgender Services. Services and supplies in connection with transgender services, except as specifically stated in the “Transgender Services” provision under the section MEDICAL CARE THAT IS COVERED.

Sterilization Reversal. Procedures intended to restore reproductive function after voluntary tubal ligation, vasectomy, or similar procedure.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

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

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

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

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

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

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

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 PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

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

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

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

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

**Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. 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 PEVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.
Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

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

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

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

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.

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

BENEFITS FOR PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM

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, coinsurance, 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 for office visits to physicians, whether services are provided in the provider’s office or in the patient’s home. Services provided in a facility, such as the outpatient department of a hospital, will be covered under plan benefits that apply to such facilities.

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, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

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, 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.

The claims administrator's network of participating providers is limited to licensed Qualified Autism Service Providers who contract with the claims administrators.
administrator and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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, 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. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us 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 fail 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 without the plan's prior written consent. 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 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 notify the plan promptly 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.

• 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 fail 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.

The plan administrator 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.
YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS

After we determine *prescription drug covered expense*, we will subtract your Prescription Drug Co-Payment for each prescription.

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

The Prescription Drug Co-Payments are set forth in the SUMMARY OF BENEFITS on page 6.
HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a member covered for prescription drug benefits, you will be issued an identification card. You must present this card to participating pharmacies when you have a prescription filled. Provided you have properly identified yourself as a member, a participating pharmacy will only charge your Co-Payment.

Many participating pharmacies display an "Rx" decal with the claims administrator’s logo in their window. For information on how to locate a participating pharmacy in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

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

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

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872
Non-participating pharmacies do not have the necessary prescription drug claim forms. You must take a claim form with you to a non-participating pharmacy. The pharmacist must complete the pharmacy’s portion of the form and sign it.

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

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

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

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

Your first mail service prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent mail service prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.
PRESCRIPTION DRUG UTILIZATION REVIEW

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

PRESCRIPTION DRUG FORMULARY

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

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

Prior Authorization. Certain drugs require written prior authorization in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if it’s determined that it should be clinically effective for you. However, if it’s determined through prior authorization that the drug originally prescribed is medically necessary, you will be provided the drug originally requested at the applicable co-payment. (If, when you first become a member, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, and you underwent a prior authorization process under the prior plan which required you to take different drugs, the claims administrator will not require you to try a drug other than the one you are currently taking.) If approved, drugs requiring prior authorization for benefits will be provided to you after you make the required co-payment.
In order for you to get a drug that requires prior authorization, your physician must make a written request to the claims administrator for you to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be facsimiled or mailed to the claims administrator. If your physician needs a copy of the form, he or she may call the claims administrator at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at www.anthem.com/ca.

If the request is for urgently needed drugs, after the claims administrator gets the Outpatient Prescription Drug Prior Authorization of Benefits form:

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

- If more information is needed to make a decision, or the claims administrator cannot make a decision for any reason, they will tell your physician, within 24-hours after they get the form, what information is missing and why they cannot make a decision. If, for reasons beyond their control, the claims administrator cannot tell your physician what information is missing within 24-hours, they will tell your physician that there is a problem as soon as they know that they cannot respond within 24-hours. In either event, the claims administrator will tell you and your physician that there is a problem – always in writing by facsimile and, when appropriate, by telephone to your physician and in writing by mail to you.

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

If the request is not for urgently needed drugs, after the claims administrator gets the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as medically necessary, the claims administrator will review it and decide if they will approve benefits within 5-business days. The claims administrator will tell you and your physician what they have decided in writing - by fax to your physician, and by mail, to you.
• If more information is needed to make a decision, the claims administrator will tell your physician in writing within 5-business days after they get the request—what information is missing and why they cannot make a decision. If, for reasons beyond their control, they cannot tell your physician what information is missing within 5-business days, they will tell your physician that there is a problem as soon as they know that they cannot respond within 5-business days. In any event, they will tell you and your physician that there is a problem in writing by facsimile, and when appropriate, by telephone to your physician, and in writing to you by mail.

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

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

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

If the claims administrator denies a request for prior authorization of a drug that is not part of the formulary drug list, you or your prescribing physician may appeal the decision by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

• Your coverage under this plan ends;

• The plan with the plan administrator terminates;

• You reach a benefit maximum that applies to prescription drugs, if the plan includes such a maximum;
Your prescription drug benefits under the plan change so that prescription drugs are no longer covered or are covered in a different way.

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

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

**PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS**

Your prescription drug benefits include certain preventive drugs, medications, and other items as listed below that may be covered under this plan as preventive care services. In order to be covered as a preventive care service, these items must be prescribed by a physician and obtained from a participating pharmacy or through the home delivery program. This includes items that can be obtained over the counter for which a physician’s prescription is not required by law.

When these items are covered as preventive care services, the Calendar Year Deductible, if any, will not apply and no co-payment will apply. In addition, any separate deductible that applies to prescription drugs will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a preventive care service, in addition to the requirements stated above, contraceptive prescription drugs must be generic drugs or single source brand name drugs.

- Shingles, seasonal flu and pneumonia vaccinations.

- Prescription drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.

- FDA-approved smoking cessation products and over-the-counter nicotine replacement products. Coverage is provided as follows, in accordance with current FDA guidelines:
  - You must be at least 18 years old.
− Coverage is limited to skin patches, chewing gum, and lozenges, for up to a 30-day supply per product, per prescription.

− Coverage is limited to one of the above products at a time, for up to three months per product.

• Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.

• Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).

• Vitamin D for women over age 65.

• Iron supplements for children from birth through 12 months old.

• Fluoride supplements for children from birth through 6 years old (drops or tablets).

**PRESCRIPTION DRUG CONDITIONS OF SERVICE**

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws. This requirement will not apply to covered vaccinations provided at a participating pharmacy.

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

3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered.
   a. Formulas prescribed by a physician for the treatment of phenylketonuria.
   b. Vaccinations provided at a participating pharmacy as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.
   c. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.

4. It must be dispensed from a licensed retail pharmacy, or through your mail service program.
5. If it is an approved compound medication, be dispensed by a participating pharmacy. Call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out where to take your prescription for an approved compound medication to be filled. (You can also find a participating pharmacy at www.anthem.com/ca.) Some compound medications must be approved before you can get them (See PREFERRED DRUG PROGRAM: PRIOR AUTHORIZATION). You will have to pay the full cost of the compound medications you get from a pharmacy that is not a participating pharmacy.

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

7. For a retail pharmacy, the prescription must not exceed a 30-day supply.

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

FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS.

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

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

10. Certain drugs have specific quantity supply limits based on the claims administrator’s analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

11. Drugs for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail pharmacies only. Documented evidence of contributing medical condition must be submitted to the claims administrator for review.
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient drugs and medications which the law restricts to sale by prescription, except as specifically stated in this section. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copayment for brand name drugs.

2. Insulin.

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

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

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

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

8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for brand name drugs.

8. Prescription drugs, vaccinations, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.

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

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. This exclusion will not apply to seasonal flu and pneumonia vaccinations, or to those listed as covered by the PreventiveRx program, if included, provided at a participating pharmacy. This exclusion will not apply to vaccinations listed as covered under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, or to those listed as covered by the PreventiveRx program, if included, provided at a participating pharmacy.
2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable drugs or medications.

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

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

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

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

Note: Vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a physician's prescription, subject to all terms of this plan that apply to those benefits.

7. Drugs and medications dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanitorium, convalescent hospital, or similar facility.

8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a physician, except prescription contraceptive diaphragms as specified under PREVENTIVE PRESCRIPTION DRUGS AND SUPPLIES THAT ARE COVERED OTHER ITEMS.

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


11. Cosmetics and health or beauty aids.

12. Drugs labeled "Caution, Limited by Federal Law to Investigational Use" or experimental drugs. Drugs or medications prescribed for experimental indications.

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

14. Drugs which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration.
15. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles).

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

17. Anorexiants and drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants). This exclusion does not apply to *drugs* used for weight loss which are listed as covered under the PreventiveRx program, if included.

18. *Drugs* obtained outside of the United States.

19. Allergy desensitization products or allergy serum.

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

21. Select classes of drugs where non-preferred medications, which have therapeutic alternatives, have shown no benefit regarding efficacy or side effect over *preferred drugs*. However, this will not apply if the prescriber denotes “dispense as written” or “do not substitute”.

22. Herbal, nutritional and dietary supplements except formulas prescribed by a *physician* for the treatment of phenylketonuria. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a *physician’s prescription*, subject to all terms of this plan that apply to those benefits.

23. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.

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

**COORDINATION OF BENEFITS**

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

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by 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.

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 trusteed 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, including a self-insured 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

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 includes Medicare in all cases except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a subscriber pays before a plan which covers you as a dependent. But, if you are a Medicare member and also a dependent of a subscriber with current employment status under another plan, this rule might change. If, according to Medicare’s rules, Medicare pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as a subscriber.

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

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

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

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

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

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

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

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

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

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

Beneficiaries entitled to Medicare receive the full benefits of this plan, except for those beneficiaries listed below:

1. Beneficiaries who are receiving treatment for end-stage renal disease following the first 30 months such beneficiaries are entitled to end-stage renal disease benefits under Medicare; and
2. Beneficiaries who are entitled to Medicare benefits as disabled persons; unless the beneficiaries have a current employment status, as determined by Medicare rules, through a group of 100 or more employees (according to OBRA legislation).

In cases where exceptions 1 or 2 apply, payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

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, coinsurance, 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 covered expense for the covered services.

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

**UTILIZATION REVIEW PROGRAM**

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

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

**Important:** The Utilization Review Program requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for you or your dependents.
The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if the claims administrator has determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by the claims administrator and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

This plan includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This plan requires that covered services be medically necessary for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. Participating providers will initiate the review on your behalf. A non-participating provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your physician to request pre-service review. You may also call the claims administrator directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The claims administrator may determine that a service that was initially prescribed or requested is not medically necessary if you have not previously tried alternative treatments that are more cost effective.

It is your responsibility to determine whether a particular service requires pre-service authorization. Please read the following information that follows to assist you in this determination and please feel free to visit www.anthem.com or call the toll-free number for pre-service printed on your identification card if you have any questions about making this determination.

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

The stages of utilization review are pre-service review, care coordination review, and retrospective review.

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

- Scheduled, non-emergency inpatient hospital stays and residential treatment center admissions.
  
  Exceptions: Pre-service review is not required for inpatient hospital stays for the following services:
  - Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and
  - Mastectomy and lymph node dissection.
- Specific non-emergency outpatient services, including diagnostic treatment and other services.
- Specific outpatient surgeries performed in an outpatient facility or a doctor's office.
- Transplant services.
- Air ambulance in a non-medical emergency.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. While there is no limit on the number of covered visits for medically necessary physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance.
  - Specific durable medical equipment.
  - Infusion therapy.
  - Home health care.
  - Admissions to a skilled nursing facility.
  - Bariatric surgical services performed at a Centers of Medical Excellence (CME) facility.
• Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

• Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.

• Transgender Services

Care coordination review determines whether services are medically necessary and appropriate when the claims administrator is notified while service is ongoing, for example, an emergency admission to the hospital.

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

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this plan. When pre-service review is not performed as required for an inpatient hospital or residential treatment center admission, specific outpatient services, including diagnostic treatment and other services, specific outpatient surgeries performed in an outpatient facility or a doctor’s office or for facility-based care for the treatment of mental or nervous disorders and substance abuse, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible of $250.

2. When pre-service review is performed and the admission, procedure or service is determined to be medically necessary and appropriate, benefits will be provided for the following:

• Transplant services as follows:
a. For bone, skin or cornea transplants, if the physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) facility.

- Air ambulance in a non-medical emergency.

- A specified number of additional visits for physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Physical Therapy, Physical Medicine or Occupational Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. While there is no limit on the number of covered visits for medically necessary physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance.

- Specific durable medical equipment.

- Services of a home infusion therapy provider if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.

- Home health care services if:
  a. The services can be safely provided in your home, as certified by your attending physician;
  b. Your attending physician manages and directs your medical care at home; and
  c. Your attending physician has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the home health agency.

- Services provided in a skilled nursing facility if you require daily skilled nursing or rehabilitation, as certified by your attending physician.

- Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:
a. The services are to be performed for the treatment of morbid obesity;

b. The physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

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

• Advanced 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.

• Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.

• Transgender Services

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

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

This means that it is extremely important to obtain pre-service or concurrent utilization review whenever possible. If you do not obtain the appropriate review before a service is obtained or during the delivery of a service, it is possible that all or part of the services will not be determined to be medically necessary and appropriate, as determined by the claims administrator, and you will be personally responsible for all charges for those services. These amounts could be substantial. In addition, you will be subject to a non-certification deductible penalty of $250.
HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
2. You must tell your physician that this plan requires pre-service review. Physicians who are participating providers will initiate the review on your behalf. A non-participating provider may initiate the review for you, or you may call the claims administrator directly. The toll-free number for pre-service review is printed on your identification card.
3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. The claims administrator will determine if services are medically necessary and appropriate. For inpatient hospital and residential treatment center stays, the claims administrator will, if appropriate, specify a specific length of stay for services. You, your physician and the provider of the service will receive a written confirmation showing this information.

Care Coordination Reviews

1. If pre-service review was not performed, you, your physician or the provider of the service must contact the claims administrator for care coordination review. For an emergency admission or procedure, the claims administrator must be notified within one working day of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.
2. When participating providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a non-participating provider to call the toll free number printed on your identification card or you may call directly.
3. When the claims administrator determines that the service is medically necessary and appropriate, they will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. The claims administrator will also determine the medically appropriate setting.

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

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

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

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

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

   This means that no benefits will be paid for services that have been denied certification, that you will be responsible for payment in full for any benefit or service received and that previously paid benefits which have been retrospectively denied certification must be reimbursed by you or will be used to offset any future benefit payment to which you might otherwise be entitled. These amounts could be substantial, so it is extremely important to obtain pre-service or concurrent review whenever possible.
THE MEDICAL NECESSITY REVIEW PROCESS

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

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

When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

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

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

4. If the claims administrator does not have the information they need, they will make every attempt to obtain that information from you or your physician. If unsuccessful and a delay is anticipated, the claims administrator will notify you and your physician of the delay and what is needed to make a decision. The claims administrator will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and the claims administrator’s medical policy. These criteria and policies are developed and approved by practicing providers not employed by the claims administrator, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.

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

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

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

- an explanation of the reason for the decision,
- reference of the criteria used in the decision to modify or not certify the request,
- the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
- how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the claims administrator.

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

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

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

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

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

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, the claims administrator has the right to recommend an alternative plan of treatment which may include services not covered under this plan. The plan administrator does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the claims administrator.
HOW PERSONAL CASE MANAGEMENT WORKS

The personal case management program (Case Management) helps coordinate services for members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate members who agree to take part in the Case Management program to help meet their health-related needs.

The Case Management programs are confidential and voluntary, and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any covered services you are receiving.

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

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

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

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

The claims administrator makes treatment recommendations only; any decision regarding treatment belongs to you and your physician. The plan will, in no way, compromise your freedom to make such decisions.
EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The plan administrator and claims administrator have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any member, which alternatives may be offered and the terms of the offer.

2. An authorization of services in lieu of benefits in a particular case in no way commits the claims administrator to do so in another case or for another member.

3. The personal case management program does not prevent the claims administrator from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other member.

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

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

3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)
EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, the claims administrator may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in their discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, the claims administrator may select certain qualifying health care providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The claims administrator may also exempt claims from medical review if certain conditions apply.

If the claims administrator exempts a process, health care provider, or claim from the standards that would otherwise apply, the claims administrator is in no way obligated to do so in the future, or to do so for any other health care provider, claim, or member. The claims administrator may stop or modify any such exemption with or without advance notice.

The claims administrator also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then the claims administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this plan’s members.

You may determine whether a health care provider participates in certain programs by checking the claims administrator’s online provider directory on the website at www.anthemcom/ca or by calling the customer service telephone number listed on your ID card.
QUALITY ASSURANCE

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

You are eligible to enroll for medical coverage benefits if you are a regular full-time Employee who is scheduled to work more than 30 hours per week. You are also eligible to enroll if you are a Branch Campus Assistant Director, Branch Campus Librarian, Branch Campus Library Assistant, or a staff member participating in the USF Voluntary Reduction in Time (VRT) Program scheduled to work at least 20 hours per week. In addition, you are eligible if you are a Jesuit member of the USF Jesuit Community or an otherwise eligible employee of the Fromm Institute, Loyola House, or St. Ignatius Church. You may also be eligible for continued coverage as may be provided under the terms of a severance or separation agreement. If you are a retired employee at least 60 years of age but less than 65 years of age and not eligible for Medicare, and you have at least ten (10) consecutive years of full-time employment with USF immediately prior to your retirement, you are eligible to continue participation in the health plans, dental plan, vision plan and long term care insurance plan ONLY. Early retirees are solely responsible for payment of all premiums due for their coverage. You may also be eligible for medical benefits for a limited period of time if you are an approved participant in the Phased-in Retirement Program for Law School Faculty.

Your eligible Dependents may also participate in the Plan(s), as applicable. An eligible Dependent is considered to be:
• your Spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages or Registered Domestic Partner (RDP), or your Legally Domiciled Adult (LDA) enrolled as of December 31, 2011;

• your or your Spouse’s, RDP’s or grandfathered LDA’s child who is under age 26 and who does not have separate health coverage available from his or her employer
  o including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or

• an unmarried child who is primarily dependent on you or your Spouse, RDP or LDA for financial support and has a mental or physical disability that began before age 26 (please refer to the section “Coverage for a Disabled Child”).

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other equivalent court or administrative order.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

Your Spouse is defined as the individual you’re legally married to under the laws of the state in which you live.

A Registered Domestic Partner (RDP) is defined as set forth in California Family Code Section 297.

Domestic Partners as described above shall file a Declaration of Domestic Partnership with the California Secretary of State and submit to the University a Certificate of Registered Domestic Partnership in order to establish eligible dependent status under the terms of this Plan.

For employees who have enrolled a Legally Domiciled Adult (LDA) for coverage on or before December 31, 2011, the LDA will be eligible to continue his or her participation in the Plan as a dependent after January 1, 2012 for as long as he or she remains otherwise eligible pursuant to the eligibility criteria applicable to LDA’s in effect as of December 31, 2011. No new enrollment of an LDA will be permitted beginning January 1, 2012. Any LDA who terminates coverage on or after January 1, 2012 will not be eligible to re-enroll for LDA coverage.

A Legally Domiciled Adult (LDA) is defined as an individual of the same or opposite sex with whom you have established a relationship as described below.
A Legally Domiciled Adult relationship is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited in the State of California;
- not be legally married to, or the LDA of, another person under either statutory or common law;
- be at least 18 years old;
- live together in the same principal residence and share the common necessities of life;
- intend to remain each other’s sole LDA indefinitely; and,
- not be receiving benefits from any other employer (however, an LDA who is receiving medical but not dental benefits from his or her employer is eligible for dental but not medical benefits from USF).

The Employee and LDA must jointly sign an affidavit of LDA status provided by the University upon request. Additional documentation may be required.

An LDA is also an adult, dependent parent or child of a participating employee, no longer otherwise eligible for benefits from the University’s benefit plans and living in the same primary residence as the employee and claimed as a tax dependent by the employee. Dependent children of these LDA’s are NOT eligible for coverage.

If you and your Spouse, RDP or LDA are both covered under a University health Plan, you may be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse, RDP or LDA are both covered as Employees under a University health Plan, only one parent may enroll your child as a Dependent. “Spouse,” “RDP,” “LDA” and “Child” do not include any person who is in active duty in the armed forces.

Note: If your Spouse is already enrolled in a USF welfare benefits plan, you cannot enroll an LDA in addition to your Spouse. Employees are allowed to enroll either one eligible Spouse or one eligible LDA.

**Coverage for a Disabled Child**
If an unmarried enrolled Dependent child with a mental or physical disability reaches age 26, the Plan will continue to cover the child as long as:

- the child is unable to be self-supporting due to a mental or physical disability;
- the child depends primarily on you for support (i.e., you provide at least 50% of his or her financial support);
- you provide to The University of San Francisco proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached age 26; and
- you provide proof, upon The University of San Francisco's request, that the child continues to meet these conditions.

The proof might include medical examinations at The University of San Francisco's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days of request, the Plan will no longer pay Benefits for that child. The definition of disability will be as set forth under the Americans with Disabilities Act (ADA) regulations.

Coverage will continue for as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

**ELIGIBILITY DATE**

1. For *subscribers*, you become eligible for coverage in accordance with rules established by your employer. For specific information about your employer’s eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. For *dependents*, you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

**Exception to the Waiting Period**

If, after you become covered under this *plan*, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible to re-enroll for coverage on the first day of the month following the date you return.
ENROLLMENT

To enroll as a subscriber, or to enroll dependents, the subscriber must properly file an application. An application is considered properly filed only if it is personally signed, dated, and given to the plan administrator within 31 days from your eligibility date. The claims administrator must receive this application within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions. The date you become covered is determined as follows:

1. Timely Enrollment: If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for subscribers, on your eligibility date; and (b) for dependents, on the later of (i) the date the subscriber's coverage begins, or (ii) the first day of the month after the dependent becomes eligible. If you become eligible before the plan takes effect, coverage begins on the effective date of the plan, provided the enrollment application is on time and in order.

2. Late Enrollment: If you do not enroll within 31 days of your eligibility date, you must wait until the next Open Enrollment Period to enroll.

3. Disenrollment: If you voluntarily choose to disenroll from coverage under this plan, you will be eligible to reapply for coverage as set forth in the “Enrollment” provision above, during the next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the subscriber (or spouse, if the spouse is enrolled) is already covered: (1) any child born to the subscriber or spouse will be covered from the moment of birth; and (2) any child being adopted by the subscriber or spouse will be covered from the date on which either: (a) the adoptive child’s birth parent, or other appropriate legal authority, signs a written document granting the subscriber or spouse the right to control the health care of the child (in the absence of a written document, other evidence of the subscriber’s or spouse’s right to control the health care of the child may be used); or (b) the subscriber or spouse assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption. The written document referred to above includes, but is
not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the subscriber must enroll the child within the 31-day period by submitting a membership change form to the plan administrator.

Special Enrollment Periods

You may enroll without waiting for the plan administrator's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
   a. You were covered as an individual or dependent under either:
      i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
      ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
   b. You certified in writing at the time you became eligible for coverage under this plan that you were declining coverage under this plan or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the plan administrator's next open enrollment period to do so.
   c. Your coverage under the other health plan that covered you as an individual or dependent ended as follows:
      i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the plan administrator within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.
Loss of eligibility for coverage under an employer group health plan or health insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the plan, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the plan administrator within 60 days after the date your coverage ended.

2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your employee health plan and an application is filed within 31 days from the date the court order is issued.

3. The claims administrator does not have a written statement from the plan administrator stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the plan administrator’s next open enrollment period.

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

a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner’s children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.
Application must be made within 31 days of the birth or date of adoption or placement for adoption.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.

6. You become eligible for assistance, with respect to the cost of coverage under the employer’s group plan, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the plan administrator within 60 days after the date you are determined to be eligible for this assistance.

7. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee’s coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

**Effective date of coverage.** For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after a copy of the court order is received or of a request from the district attorney, either parent or the person having custody of the child, or the employer.

2. For enrollments following the birth, adoption, or placement for adoption of a child, coverage will be effective as of the date of birth, adoption, or placement for adoption.

3. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be
OPEN ENROLLMENT PERIOD

There is an open enrollment period once each year. This period of time is determined by agreement between BC Life and the University of San Francisco. During that time, an individual who meets the eligibility requirements as a subscriber under this plan may enroll. A subscriber may also enroll any eligible dependents at that time. Persons eligible to enroll as dependents may enroll only under the subscriber's plan.

For anyone so enrolling, coverage under this plan will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this plan begins.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the plan terminates, your coverage ends at the same time. This plan may be canceled or changed without notice to you.

2. If the plan no longer provides coverage for the class of beneficiaries to which you belong, your coverage ends on the effective date of that change. If this plan is amended to delete coverage for dependents, a dependent's coverage ends on the effective date of that change.

3. Coverage for dependents ends when subscriber's coverage ends.

4. Coverage ends at the end of the period for which the required monthly contribution has been paid on your behalf when the required monthly contribution for the next period is not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which you provide to us.

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the due date for the required monthly contribution coinciding with or following the date you cease to meet such requirements.
Exceptions to item 6:

a. **Leave of Absence.** If you are a *subscriber* and the required monthly contributions are paid, your coverage may continue for up to six months (other than a member of the faculty) during an approved leave of absence. If you are a member of the faculty, your coverage may continue for up to one (1) year. If you are a union member, please consult your collective bargaining agreement for information relating to continuation of coverage during leaves of absence. This time period may be extended if required by law.

b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan*, (ii) unmarried, (iii) still financially dependent on the *subscriber* or *spouse*, and (iv) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. The *plan administrator* must receive the certification, within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, the *plan administrator* may request proof of continuing dependency and disability, but not more often than once each year. This exception will last until the *child* is no longer handicapped or dependent on the *subscriber* or *spouse* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, and EXTENSION OF BENEFITS.
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 Member means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this plan as either a subscriber or dependent; and (b) a child who is born to or placed for adoption with the subscriber during the COBRA continuation period. Qualified Member does not include any person who was not enrolled during the Initial Enrollment Period, including any dependents acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above. It does not include domestic partners if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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 Subscribers and Dependents:
   a. The subscriber’s termination of employment, for any reason other than gross misconduct; or
   b. A reduction in the subscriber’s work hours.

2. For Retired Subscribers and their Dependents. 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.

3. For Dependents:
   a. The death of the subscriber;
   b. The spouse’s divorce or legal separation from the subscriber;
   c. The end of a child’s status as a dependent child, as defined by the plan; or
   d. The subscriber’s entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A subscriber or dependent may choose to continue coverage under the plan if his or her coverage would otherwise end for a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. We will notify either the subscriber or dependent of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the plan administrator will notify the subscriber of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a dependent will be notified of the COBRA continuation right.
3. You must inform the plan administrator within 60 days of Qualifying Events 3(b) or 3(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 all beneficiaries within a family, or only for selected beneficiaries.

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 Dependents. A spouse or child acquired during the COBRA continuation period is eligible to be enrolled as a dependent. The standard enrollment provisions of the plan apply to enrollees during the COBRA continuation period.
**Cost of Coverage.** You may be required to 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.

Besides applying to the subscriber, the subscriber's rate also applies to:

1. A spouse whose COBRA continuation began due to divorce, separation or death of the subscriber;

2. A child if neither the subscriber nor the spouse has enrolled for this COBRA continuation coverage (if more than one child is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of children enrolled); and

3. A child whose COBRA continuation began due to the person no longer meeting the dependent child definition.

**Subsequent Qualifying Events.** Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a subscriber or dependent, who is a Qualified Member, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a child may have been originally eligible for this COBRA continuation due to termination of the subscriber's employment, and enrolled for this COBRA continuation as a Qualified Member. If, during the COBRA continuation period, the child reaches the upper age limit of the plan, the child is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

**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 dependents 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 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the subscriber, divorce or legal separation, or the end of dependent child status;*

3. The end of 36 months from the date the subscriber became entitled to Medicare, if the Qualifying Event was the subscriber's entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the subscriber will end 36 months from the date the subscriber became entitled to Medicare;

4. The date the plan terminates;

5. 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; or

7. The date, following the election of COBRA, the member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*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. Additional note: If COBRA continuation under this plan began on or after January 1, 2003 and ends in accordance with item 1, the member may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before the member is eligible to further continue coverage under CalCOBRA. Please see CALCObRA CONTINUATION OF COVERAGE in this booklet for more information.

Subject to the plan remaining in effect, a retired subscriber whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered dependents may continue coverage for 36 months after the subscriber's death. But coverage could terminate prior to such time for either the subscriber or dependent in accordance with items 4, 5 or 6 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 (such as a spouse's plan) through the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less
than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**EXTENSION OF CONTINUATION DURING TOTAL DISABILITY**

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Member is determined to be disabled for Social Security purposes, all covered beneficiaries may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

**Eligibility for Extension.** To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled member must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

**Notice.** The member must furnish the plan administrator with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Member loses coverage; or
4. The date on which the Qualified Member is informed of the obligation to provide the disability notice.

**Cost of Coverage.** For the 19th through 29th months that the total disability continues, the plan administrator must remit the cost for the extended continuation coverage to us. This cost (called the "required monthly contribution") shall be subject to the following conditions:

1. If the disabled member continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled member remains covered, depending upon the number of covered dependents. If the disabled member does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us by the plan administrator each month during the period of extended continuation coverage. We must receive timely payment of the required monthly contribution each month from the plan administrator in order to maintain the extended continuation coverage in force.

3. The plan administrator may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The required monthly contribution shall then be 150% of the applicable rate for the 19th through 36th months if the disabled member remains covered. The charge will be 102% of the applicable rate for any periods of time the disabled member is not covered following the 18th month.

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event*;

3. The date the plan terminates;

4. The end of the period for which required monthly contributions are last paid;

5. The date, following the election of COBRA, the member first becomes covered under any other group health plan; or

6. The date, following the election of COBRA, the member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the plan administrator within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

*Note: If your COBRA continuation under this plan began on or after January 1, 2003 and ends in accordance with item 2, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.
CALCOBRA CONTINUATION OF COVERAGE

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or

2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. You are not eligible to further continue coverage under CalCOBRA if you (a) are entitled to Medicare; (b) have other coverage or become covered under another group plan; or (c) are eligible for or covered under federal COBRA. Coverage under CalCOBRA is available for medical benefits only.

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, the plan administrator will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify the plan administrator in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later.

Additional Dependents. A spouse or child acquired during the CalCOBRA continuation period is eligible to be enrolled as a dependent. The standard enrollment provisions of the plan apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You may be required to pay the entire cost of your CalCOBRA continuation coverage (this is the “required monthly contribution”). This cost must be remitted to the plan administrator each month during the CalCOBRA continuation period. This cost will be:

1. 110% of the applicable rate if your coverage under federal COBRA ended after 18 months; or

2. 150% of the applicable rate if your coverage under federal COBRA ended after 29 months.
CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the prior plan, your coverage may continue under this plan for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and required monthly contribution payment requirements of this plan within 30 days of receiving notice that your continuation coverage under the prior plan will end.

When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the required monthly contribution, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For dependents properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the plan.

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the plan terminates;
3. The end of the period for which the required monthly contribution is last paid;
4. The date you become covered under any other health plan;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of the service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a prior plan, this term will be dated from the time of the qualifying event under that prior plan.
EXTENSION OF BENEFITS

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

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

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

3. Your extension of benefits will end when any one of the following circumstances occurs:
   a. You are no longer totally disabled.
   b. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
   c. A period of up to 12 months has passed since your extension began.

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 is claims administrator, or any of the employees of the claims administrator, an employee or agent of any hospital, medical group or medical care provider of any type.

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

Inter-Plan Programs

1. Out of Area Services. The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs”. Whenever you obtain healthcare services outside of the service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between the claims administrator and other Blue Cross and Blue Shield Licensees.

   Typically, when accessing care outside the service area, you may obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers. The plan’s payment practices in both instances are described below.

2. BlueCard® Program. Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, the claims administrator will remain responsible for fulfilling their contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever you access covered healthcare services outside the service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

   - The billed covered charges for your covered services; or
   - The negotiated price that the Host Blue makes available to the claims administrator.
Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue pays to your healthcare provider. But sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, the claims administrator would then calculate your liability for any covered healthcare services according to applicable law.

3. Non-Participating Health Care Providers Outside Our Service Area

Member Liability Calculation. When covered health care services are provided outside of California by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue’s non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment the plan will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, the claims administrator may use other payment bases, such as billed covered charges, the payment the claims administrator would make if the health care services had been obtained within California, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the plan will pay for services rendered by non-participating health care providers. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment the plan will make for the covered services as set forth in this paragraph.
If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider’s services will be considered non-network care, and you may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on your ID card or go to www.anthem.com/ca for more information about such arrangements.

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

**Terms of Coverage**

1. In order for you to be entitled to benefits under the 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.** We do not have the right to cancel your coverage under this plan while: (1) this plan is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the plan.

**Free Choice of Provider.** This plan in no way interferes with your right as a member entitled to hospital benefits to select a hospital. You may choose any physician who holds a valid physician and surgeon’s certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. You may also choose any other health care professional or facility which provides care covered under this plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this plan.
Continuity of Care. If the claims administrator terminates its contractual relationship with a participating provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a participating provider. Coverage is provided according to the terms and conditions of this plan applicable to participating providers.

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

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 or the provider of service must send properly and fully completed claim forms to the claims administrator within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the plan if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.
Payment to Providers. The benefits of this plan will be paid directly to contracting hospitals, participating providers, CME and medical transportation providers. Also, non-contracting hospitals and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this plan will be paid to the State Department of Health Services. These payments will fulfill the plan’s obligation to you for those covered services.

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, co-payments or co-insurance, 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 plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers to the University of San Francisco or to a person or entity other than the claims administrator, engaged by the University of San Francisco 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. Your 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.

Liability to Pay Providers. In the event that the plan does not pay a provider who has provided services and supplies to you, you will be required to pay that provider any amounts not paid to them by the plan.

Renewal Provisions. The plan is subject to renewal at certain intervals. The required monthly contribution or other terms of the plan may be changed from time to time.

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”) for the provision of and payment for health care services rendered to its members and beneficiaries 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, beneficiaries 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.

**Transition Assistance for New Beneficiaries:** Transition Assistance is a process that allows for completion of covered services for new beneficiaries receiving services from a non-participating provider. If you are a new member, you may request Transition Assistance if any one of the following conditions applies:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the claims administrator in consultation with you and the non-participating provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this plan.

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

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

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls in this plan.
6. Performance of a surgery or other procedure that the claims administrator have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this plan.

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

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with non-participating providers are negotiated on a case-by-case basis. We will request that the non-participating provider agree to accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the non-participating provider does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a physician review the request.

**Continuity of Care after Termination of Provider:** Subject to the terms and conditions set forth below, benefits will be provided at the participating provider level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with the claims administrator terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the participating provider at the time the provider’s contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the claims administrator prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the claims administrator prior to termination. If the provider does not agree with these contractual terms and conditions, the provider’s services will not be continued beyond the contract termination date.
Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the claims administrator in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

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

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

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

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

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the plan.
You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis.

The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider’s services will not be continued. If you disagree with the determination regarding continuity of care, you may file complaint as described in the COMPLAINT NOTICE.

**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) within a specific 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. 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 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. If you receive a gift card 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.

**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 the customer service number on your ID card 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.

**BINDING ARBITRATION**

**Note**: If you are enrolled in a plan provided by your employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

Any dispute or claim, of whatever nature, arising 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 or claim within the jurisdictional limits of the small claims court will be resolved in such court.

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

The member and 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 arbitration, 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. The arbitration will be held at a time and location mutually agreeable to the member and the plan administrator.

**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.

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

1. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of your residence or within the county in which your residence is located, whichever is less;

2. You are referred in writing to the non-participating provider by the physician who is a participating provider, and

3. The referral has been authorized by the claims administrator before services are rendered.
Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric CME.

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

**Bariatric CME Coverage Area** is the area within the 50-mile radius surrounding a designated bariatric CME.

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

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

**Centers of Medical Excellence (CME)** are health care providers which have a Centers of Medical Excellence Agreement in effect with the claims administrator at the time services are rendered. CME agree to accept the maximum allowed amount as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a CME. A provider's participation in the Prudent Buyer Plan network or other agreement with the claims administrator is not a substitute for a Centers of Medical Excellence Agreement.

**Child** meets the plan’s eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

**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 BC Life & Health Insurance Company. On behalf of BC Life & Health Insurance Company, Blue Cross of California shall perform all administrative services in connection with the processing of claims under the plan.

**Compound Medication** is a mixture of prescription drugs and other ingredients in which the primary ingredient (the highest cost ingredient requiring a prescription) is FDA-approved, requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer. Compound medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or

2. Products lacking a National Drug Code (NDC) number.
**Contracting hospital** is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *beneficiaries*. A contracting hospital is not necessarily a *participating provider*. A list of contracting hospitals will be sent on request.

**Creditable coverage** is coverage provided by any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

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

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

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

**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 or nervous disorders* or substance abuse under the supervision of *physicians*.

**Dependent** meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.
Drug (prescription drug) means a prescribed drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public. For the purposes of this plan, insulin will be considered a prescription drug.

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a psychiatric emergency medical condition, which the member reasonably perceives could permanently endanger health if medical treatment is not received immediately. 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.

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

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

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

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization 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 or nervous disorder or substance abuse), and (2) residential treatment centers.

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.

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.

Legally domiciled adult meets the plan’s eligibility requirements for legally domicile adult as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

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. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your physician or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

c. For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the subscriber or dependent.

Mental or nervous disorders, including substance abuse, for the purposes of this plan, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental or nervous disorders include severe mental disorders as defined in this plan (see definition of “severe mental disorders”).

Non-contracting hospital is a hospital which does not have a Standard Hospital Contract in effect with the claims administrator at the time services are rendered.

Non-participating pharmacy is a pharmacy which does not have a contract in effect with the pharmacy benefits manager at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the claims administrator at the time services are rendered:

- A hospital
- A physician
- An ambulatory surgical center
- A home health agency
• A facility which provides diagnostic imaging services
• A durable medical equipment outlet
• A skilled nursing facility
• A clinical laboratory
• A home infusion therapy provider
• An urgent care center
• A retail health clinic
• A hospice
• A licensed ambulance company
• A licensed qualified autism service provider

They are not participating providers. Remember that the maximum allowed amount may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:
• A certified registered nurse anesthetist
• A blood bank

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

Participating pharmacy is a pharmacy which has a Participating Pharmacy Agreement in effect with the pharmacy benefit manager at the time services are rendered. Call your local pharmacy to determine whether it is a participating pharmacy or call the toll-free customer service telephone number.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the claims administrator at the time services are rendered:
• A hospital
• A physician
• An ambulatory surgical center
• A home health agency
• A facility which provides diagnostic imaging services
• A durable medical equipment outlet
• A skilled nursing facility
• A clinical laboratory
• A home infusion therapy provider
• An urgent care center
• A retail health clinic
• A hospice
• A licensed ambulance company
• A licensed qualified autism service provider

Participating providers agree to accept the maximum allowed amount as payment for covered services. A directory of participating providers is available upon request.

Pharmacy means a licensed retail pharmacy.

Pharmacy Benefits Manager (PBM) is the entity with which the claims administrator has contracted to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with the claims administrator.

Physician means:

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

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above (please refer to the Services of Providers under the Medical Care that is not Covered section on page 37):

• 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 for the provision of 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 practitioner
• A physician assistant
• A psychiatric mental health nurse (R.N.)*
• A nurse midwife**
• Any agency licensed by the state to provide services for the treatment of mental or nervous disorders or substance abuse, when required by law to cover those services.
• 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.

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

**If there is no nurse midwife who is a participating provider in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

Plan is the set of benefits described in this benefit booklet and in the amendments to this benefit booklet, if any. These benefits are subject to the terms and conditions of the plan. If changes are made to the plan, an amendment or revised benefit booklet will be issued to each subscriber affected by the change.

Plan administrator refers to UNIVERSITY OF SAN FRANCISCO, the entity which is responsible for the administration of the plan.

Prescription means a written order or refill notice issued by a licensed prescriber.

Prescription drug covered expense is the expense you incur for a covered prescription drug, but not more than the prescription drug maximum allowed amount. Expense is incurred on the date you receive the service or supply.
Prescription drug formulary (formulary) is a list which the claims administrator has developed of outpatient prescription drugs which may be cost-effective, therapeutic choices. Any participating pharmacy can assist you in purchasing drugs listed on the formulary. You may also get information about covered formulary drugs by calling 1-800-700-2541 or going to the internet website anthem.com/ca.

Prescription drug maximum allowed amount is the maximum amount the claims administrator will allow for any drug. The amount is determined by the claims administrator using prescription drug cost information provided to them by the pharmacy benefits manager. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

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

Please call the customer service number listed on your ID card for additional information about services that are covered by this plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

https://www.healthcare.gov/what-are-my-preventive-care-benefits
http://www.ahraq.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.

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

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 state law;
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.

Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with the claims administrator will be subject to the non-contracting hospital penalty in effect at the time of service.

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.

Registered domestic partner is defined as set forth in California Family Code Section 297.

Residential treatment center is an inpatient treatment facility where the member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental disorder, severe mental disorder,
or substance abuse. The facility must be licensed to provide psychiatric treatment of mental disorders, severe mental disorders, or rehabilitative treatment of substance abuse according to state and local laws.

**Retail Health Clinic** - 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.

**Severe mental disorders** include the following psychiatric diagnoses 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 Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child’s age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

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

**Spouse** meets the plan’s eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

**Stay** is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.
Subscriber is the person who, by meeting the plan’s eligibility requirements for subscribers, is allowed to choose membership under this plan for himself or herself and his or her eligible dependents. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

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

Totally disabled employee is a subscriber who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Transplant Centers of Medical Excellence maximum allowed amount (CME maximum allowed amount) is the fee CME agree to accept as payment for covered services. It is usually lower than their normal charge. CME maximum allowed amounts are determined by Centers of Medical Excellence Agreements.

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 the customer service number listed on your ID card or you can also search online using the “Provider Finder” function on the website at www.anthem.com/ca. Please call the urgent care center directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to UNIVERSITY OF SAN FRANCISCO.

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

You (your) refers to the subscriber and 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:

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

The procedure the claims administrator 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;
• 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 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. 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

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.

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, 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

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. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or 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 filing a lawsuit or taking other legal action of any kind against the Plan.

If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

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 the 800 number on your identification card. Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross's web site to access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card. Simply log on to www.anthem.com/ca, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site.

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.

To requesting a written or oral translation, please contact customer service by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance.

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

**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 the customer service telephone number listed on your ID card.
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 the customer service telephone number listed on your ID card.
GENERAL PLAN INFORMATION

The following information, together with the preceding material, forms a Benefit Booklet under the Employee Retirement Income Security Act of 1974 (ERISA). The benefit booklet covers group medical coverage to eligible employees of University of San Francisco. The University of San Francisco Group Medical Plan is administered on a self-insured basis with benefit claims processed by Anthem Blue Cross, on behalf of Anthem Blue Cross Life and Health Insurance Company (Claims Administrator).

1. **Plan Name.** The designated name of the Plan is: University of San Francisco Group Medical Plan.

2. **Plan Sponsor.** The name and address of the entity which established and maintains the Plan is:

   University of San Francisco
   2130 Fulton Street
   San Francisco, CA 94117

3. **Plan Numbers:**

   The Employer's Identification Number (EIN) is 94-1156628.

   The Plan Number is 501.

4. **Type of Plan.** The Plan is an employee welfare benefit plan providing group medical benefits.

5. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on January 1st and ending on the following December 31st.

6. **Type of Administration/Funding.** Benefits are furnished under a health care plan funded by the Plan Sponsor. BC Life furnishes only certain claim processing and provider contracting services and has no financial responsibility for benefits.

   University of San Francisco's address is:
   2130 Fulton Street
   San Francisco, CA 94117
7. **Plan Administrator.** The name, address and telephone number of the Plan Administrator is:

   University of San Francisco
   2130 Fulton Street
   San Francisco, CA  94117
   Telephone No. (415) 422-6707

8. **Agent for Service of Legal Process.** The name and address of the designated agent for the service of legal process for the Plan is:

   University of San Francisco
   2130 Fulton Street
   San Francisco, CA  94117

9. **Description of Benefits.** The Benefit Booklet sets forth the benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is provided under the Prudent Buyer Plan. A brief explanation of these benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is covered may be found in the section entitled SUMMARY OF BENEFITS. A more detailed description of the benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is covered appears in the sections entitled in the sections entitled TYPES OF PROVIDERS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS, YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT, YOUR MEDICAL BENEFITS: DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS, YOUR MEDICAL BENEFITS: CONDITIONS OF COVERAGE, YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED, YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, SUBROGATION AND REIMBURSEMENT, YOUR PRESCRIPTION DRUGS BENEFITS, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG COVERED EXPENSE, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG COVERAGE, YOUR PRESCRIPTION DRUGS BENEFITS: PREFERRED DRUG PROGRAM, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG CONDITIONS OF SERVICE, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED, YOUR PRESCRIPTION DRUGS BENEFITS, PRESCRIPTION DRUGS SERVICES AND SUPPLIES THAT ARE NOT COVERED, COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES, MEDICATION MANAGEMENT PROGRAMS, UTILIZATION REVIEW PROGRAM, and DEFINITIONS.
Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

10. Eligibility for Participation. The eligibility requirements for participation under the Prudent Buyer Plan are set forth in the Benefit Booklet in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.

11. Grounds for Ineligibility or Loss or Denial of Benefits. Details describing the circumstances which may result in: (a) disqualification from the Prudent Buyer Plan; (b) ineligibility for benefits; or (c) denial, loss, forfeiture or suspension of benefits under the Plan are set forth and identified in the Benefit Booklet, as outlined below:

- Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.

- Benefits may be denied or suspended if statements a plan participant has made in connection with obtaining coverage were false.

- Information concerning situations under which benefits may be reduced or denied may also be found in the sections entitled TYPES OF PROVIDERS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS, YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT, YOUR MEDICAL BENEFITS: DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS, YOUR MEDICAL BENEFITS: CONDITIONS OF COVERAGE, YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED, YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, SUBROGATION AND REIMBURSEMENT, YOUR PRESCRIPTION DRUGS BENEFITS, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG COVERED EXPENSE, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG UTILIZATION REVIEW, YOUR PRESCRIPTION DRUGS BENEFITS: PREFERRED DRUG PROGRAM, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG CONDITIONS OF SERVICE, YOUR PRESCRIPTION DRUGS BENEFITS: PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED, YOUR PRESCRIPTION DRUGS BENEFITS, PRESCRIPTION DRUGS SERVICES AND SUPPLIES THAT ARE NOT COVERED, COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES, UTILIZATION REVIEW PROGRAM, and DEFINITIONS.
12. **Claims Procedures.** The plan document and this booklet entitled “Benefit Booklet,” contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.) In addition to this information, ERISA applies some additional claim procedure rules. The addition rules required by ERISA are set forth below.

**Urgent Care.** The Claims Administrator must notify you, within 72-hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24-hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48-hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72-hours after the Claims Administrator’s receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180-days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72-hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

**Non-Urgent Care Pre-Service (when care has not yet been received).** The Claims Administrator must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits.
But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30-days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

**Concurrent Care Decisions:**

- **Reduction of Benefits** – If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:
  
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
  
  - To keep the benefits you already have approved, you must successfully appeal the Claims Administrator’s decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section “Urgent Care,” above), depending upon the circumstances of your condition.
If the Claims Administrator receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).

**Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

- You must make a request to the Claims Administrator for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

- If the Claims Administrator receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

**Non-Urgent Care Post-Service (reimbursement for cost of medical care)**. The Claims Administrator must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits.
But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their decision. Your appeal must be in writing. Within 60-days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your member, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms "urgent care," "Non-Urgent Care Pre-Service," and "Non-Urgent Care Post-Service," used in this provision, have the meanings set forth by ERISA for a "claim involving urgent care," "pre-service claim," and "post-service claim," respectively.
STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Benefit Booklet. The Plan Administrator may make a reasonable charge for the copies;

- Receive a summary of the Plan’s annual financial report; the Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Benefit Booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of your benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials requested and to pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, except that, any dispute concerning denial or partial denial of a claim must be resolved by binding arbitration as provided in the Plan booklet, unless otherwise prohibited under any applicable state or federal law. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are unsuccessful, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.