

**UNIVERSITY OF CALIFORNIA
STUDENT HEALTH INSURANCE PLAN
(UC SHIP)
Medical Benefits**

**UC MERCED
Students and Dependents**

2016 – 2017 Plan Year

***Prudent Buyer Plan
Benefit Booklet***

Dear Plan Member:

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

Covered students and dependents (“members”) 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 in the DEFINITIONS section of this Booklet.

Please read this Benefit Booklet carefully so that you understand all the benefits your *plan* offers. Please review Your Right to Appeals section below in order to understand your rights of dispute or claim under UC SHIP. Keep this Benefit Booklet handy in case you have any questions about your coverage.

Note: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any amendments hereto are funded by the University. Anthem Blue Cross Life and Health Insurance Company performs all administrative services in connection with the processing of claims under the *plan* and has full and final discretion and authority to determine whether and to what extent members are entitled to benefits under the *plan*. Anthem Blue Cross Life and Health Insurance Company does not assume any financial risk or obligation with respect to the funding of benefits.

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

UC SHIP Customer Service Number: 1-866-940-8306

UC SHIP website: www.ucop.edu/ucship

COMPLAINT NOTICE

All complaints and disputes relating to benefits provided by this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number that appears on your ID 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). If you wish, the *claims administrator* will provide a Complaint Form which you may use to explain the matter.

All grievances regarding benefits will be acknowledged in writing, together with a description of how the *claims administrator* proposes to resolve the grievance.

Grievances relating to eligibility for coverage under the *plan* should be submitted to your campus student health insurance office in writing, within 60 days of the notification that you are not eligible for coverage. You should include all information and documentation on which your grievance is based. The student health insurance office will notify you in writing of its conclusion regarding your eligibility. If the student health insurance office confirms the determination that you are ineligible, you may request, in writing, that the University of California Student Health Insurance Plan (UC SHIP) office review this decision. Your request for review should be sent within 60 days after receipt of the notice from the student health insurance office confirming your ineligibility and should include all information and documentation relevant to your grievance. Your request for review should be submitted to: University of California Student Health Insurance Plan, Risk Services, 1111 Franklin Street, 10th Floor, Oakland, CA 94607. The decision of the UC SHIP Director will be final.

UC SHIP Customer Service Number: 1-866-940-8306

UC SHIP website: www.ucop.edu/ucship

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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 service or for which you may need to obtain approval or referral in advance.
- A post-service claim is a 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 follow will satisfy the requirements for a full and fair review under applicable law.

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;
- 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 claim 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 72 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 communicated between the *claims administrator* and you by telephone, or sent by facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the *claims administrator* at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;

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

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

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

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

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

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

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

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, upon 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 the health care professional who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review.

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 the 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 our 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 communicated between the *claims administrator* and you by telephone, or sent by facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the *claims administrator* at the phone number listed on your ID card and provide at least the following information:

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

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

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

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

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

Requirement to file an Appeal before seeking other remedies

If you are still dissatisfied with the resolution after you have completed the Appeals Procedure, you may initiate proceedings in a court of law or other forum or file a claim in small claims court, depending on the amount you are seeking. Any such action must be commenced within three years of the *plan's* final decision on the claim or other request for benefits. If the *plan* determines 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, other than any voluntary level of appeal, before filing a lawsuit or taking other legal action, including filing a claim in small claims court, against the plan.

We reserve the right to modify the policies, procedures and timeframes in this section in accordance with applicable law.

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INTRODUCTION TO THE UC STUDENT HEALTH INSURANCE PLAN

Medical Benefits

Students of the University of California should seek non-emergency or non-urgent medical care at student health services on campus. Student health services is your medical home, and they can diagnose and treat most illnesses and coordinate all of your healthcare.

Students at UC Merced and covered dependents may seek medical services off campus from any health care professional or facility. A referral from a Primary Care Physician (PCP) (e.g., a Family Practice, General Medicine or Internal Medicine Physician) is required prior to seeking care from a Specialist. The referral does not guarantee payment or coverage. With the referral in hand you choose from *UC Family, network*, or *out-of-network providers*. Review the benefits listed in this Booklet to determine your most cost-effective option. The services must be medically necessary and a covered benefit under this plan.

Note: Student health services on campus does not provide medical or pharmacy services for covered *dependents*.

Prior referral from a Primary Care Physician is not required for emergency room or urgent care clinic services, or the services of a pediatrician, an obstetrician for pre-natal and maternity care, or a gynecologist. No referral is required for Pediatric Vision and Dental benefits covered under UC SHIP for members under age 19.

Payment of *emergency* room claims is subject to review by the *claims administrator*. The *claims administrator* makes the final determination regarding whether services were rendered for an *emergency*.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

Insured Students

1. All registered domestic and international students at the University of California Merced campus, including students who are registered in-absentia are automatically enrolled in UC SHIP.

Note: A student may waive enrollment in the *plan* during the specified waiver period by providing proof of other coverage that meets benefit criteria specified by the University. A waiver is effective for one academic year and must be completed again during the waiver period at the start of each fall term of the academic year. Waiver requests for each academic term within a year are also available. Information about waiving enrollment in the *plan* may be obtained from the student health services on campus.

Eligible Non-Registered Students

1. The following classes of individuals may enroll voluntarily as insured students:
 - a. All non-registered Filing Fee status graduate students of the University of California who are completing work under the auspices of the University of California but are not attending classes. Students on Filing Fee status may purchase *plan* coverage for a maximum of one semester by contacting Wells Fargo Insurance Services at 1-800-853-5899. The student must have been covered by the *plan* in the term immediately preceding the term for which the student wants to purchase coverage or, if the student waived *plan* enrollment, show proof of involuntary loss of the coverage used to obtain the waiver.
 - b. All non-registered students of the University of California who are on a Planned Educational Leave. While in this status, students may purchase *plan* coverage for a maximum of one semester. The student must have been covered by the *plan* in the term immediately preceding the term for which the student wants to purchase coverage or, if the student waived *plan* enrollment, show proof of involuntary loss of the coverage used to obtain the waiver. These students may enroll by contacting Wells Fargo Insurance Services at 1-800-853-5899.

- c. All former students of the University of California who completed their degree at UC (graduated) during the term immediately preceding the term for which they want to purchase coverage. Provided these individuals were enrolled in the *plan* in the preceding term, they may purchase the *plan* coverage for a maximum of one semester. These individuals may enroll by contacting Wells Fargo Insurance Services at 1-800-853-5899.

Eligible Dependents

1. The following classes of dependents of insured students may enroll voluntarily in the *plan*:
 - a. Spouse: Legally married *spouse* of the *insured student*.
 - b. Domestic Partner: The individual designated as an *insured student's domestic partner* under one of the following methods: (i) registration of the partnership with the State of California; (ii) establishment of a same-sex legal union, other than marriage, formed in another jurisdiction that is substantially equivalent to a State of California-registered domestic partnership; or (iii) filing of a Declaration of Domestic Partnership form with the University. An *insured student's* opposite-sex *domestic partner* will be eligible for coverage only if one or both partners are age 62 or older and eligible for Social Security benefits based on age.
 - c. Child: The *insured student's child(ren)* as follows:
 - Biological *child* under the age of 26.
 - Stepchild: A stepchild under the age of 26 is a *dependent* as of the date the *insured student* marries the *child's* parent.
 - Adopted *child* under the age of 26, including a *child* placed with the *insured student* or the *insured student's spouse* or *domestic partner*, for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
 - *Child* of the *insured student's domestic partner*: A *child* of the *insured student's domestic partner* under the age of 26 is a *dependent* as of the *effective date* of the domestic partnership.
 - Foster Child: A foster *child* under the age of 18 is a *dependent* from the moment of placement with the *insured student* as certified by the agency making the placement. In certain circumstances, the foster *child* age limit may be extended in accordance with the provision for a non-minor

dependent, as defined in the California Welfare and Institutions Code Section 11400(v).

- A *child* for whom the insured student is legally required to provide health insurance in accordance with an administrative or court order, provided that the child otherwise meets UC SHIP eligibility requirements.
- Dependent Adult Child: A *child* who is 26 years of age or older and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* is incapable of self-sustaining employment due to a physical or mental condition. The University may request proof of these conditions in order to continue coverage. The University must receive the certification, at no expense to the University, within 60 days of the date the *student* receives the request. The University may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the *child* is no longer chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A dependent adult *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a *dependent* for federal income tax purposes.

NOTE: If both student parents are covered as insured students, their children may be covered as the dependents of either, but not of both.

2. Students are required to provide proof of *dependent* status when enrolling their dependents in the *plan*. Proof is required once per year. The following documents will be accepted:
 - a. For *spouse*, a marriage certificate
 - b. For a *domestic partner*, a Certificate of Registered Domestic Partnership issued by the State of California, or of same-sex legal union other than marriage formed in another jurisdiction, or a completed Declaration of Domestic Partnership form issued by the University
 - c. For a biological *child*, a birth certificate showing the student is the parent of the *child*

- d. For a stepchild, a birth certificate, and a marriage certificate showing that one of the individuals listed on the birth certificate is married to the student
- e. For a biological *child of a domestic partner*, a birth certificate showing the *domestic partner* is the parent of the *child*
- f. For an adopted or foster *child*, documentation from the placement agency showing that the student or the *domestic partner* has the legal right to control the *child's* health care
- g. For a child covered under a court order, a copy of the document from the court

PERIODS OF COVERAGE

	FALL	SPRING
Coverage periods	8/15/2016-1/14/2017	1/15/2017-8/14/2017

ENROLLMENT

We do not require written applications from registered students. The University of California will maintain records of all students registered each academic term and will automatically enroll all registered students for coverage under this *plan* each academic term. Students who provide proof that they have other health coverage that meets the University's requirements may apply to waive enrollment in the *plan*.

Students who involuntarily lose their other health coverage during the *coverage period* must notify the student health services on their campus with an official written letter of termination from the previous health insurance carrier. These students will be enrolled in UC SHIP as of the date of their involuntary loss of other coverage if they notify the student health services within 31 days of the loss of their coverage. If the student does not notify the student health services within the 31 days, coverage will be effective on the date the student pays the full premium. The premium is not pro-rated for enrollment occurring after the start of a *coverage period*.

Non-registered students and eligible dependents who enroll on a voluntary basis must submit an enrollment application for each academic term of coverage. Enrollment applications must be received within the dates of the enrollment period for the term of coverage. **Enrollment will not be continued to the next *coverage period* (academic term) unless a new application is received.**

Dependents of covered students may be enrolled, outside of an enrollment period for a particular *coverage period*, within 31 calendar days of the following events:

1. For *spouse*, the date of issuance of the marriage certificate.
2. For a *domestic partner*, the date that the Certificate of Registered Domestic Partnership is filed with the State of California, other jurisdiction, or the date the completed Declaration of Domestic Partnership form issued by the University is received by the student health services.
3. For a biological *child*, the date of birth.
4. For an adopted or foster *child*, the date of placement with the student or *domestic partner*.
5. For any *dependent*, the date of loss of other coverage. An official letter of termination from the insurance carrier must be provided at the time of enrollment in UC SHIP.
6. For a child covered under a court order, the date that the court orders that the child be covered.

Non-registered students and eligible dependents enroll by contacting Wells Fargo Insurance Services at 1-800-853-5899.

Important Note Regarding Newborn Children. If the student is already covered, any *child* born to the student will be covered under the student's benefits from the moment of birth, provided Anthem Blue Cross is notified of the birth within 31 days. Coverage will be in effect for 31 days under the covered parent's *plan* without additional cost to the student.

For continued newborn coverage beyond the 31 days, the parent must enroll the newborn as a *dependent* under UC SHIP within 31 days of the date of birth. The student must contact Wells Fargo Insurance Services to enroll the *child* as a *dependent*. Their Customer Care telephone number is 1-800-853-5899.

HOW COVERAGE ENDS

For students, coverage ends as provided below:

1. If the *plan* terminates, the student's coverage ends at the same time. This *plan* may be canceled or changed at any time without notice. If the *plan* terminates or changes, an *insured student* will remain covered for claims incurred but not filed or paid prior to *plan* termination or change.
2. If the *plan* no longer provides coverage for the class of students to which an *insured student* belongs, the student's coverage ends on the *effective date* of that change.
3. If the student graduates from the University, the student's coverage continues through the last day of the *coverage period* during which the student graduates from the University.
4. If the student withdraws or is dismissed from the University, whether or not coverage will be continued after the date of the withdrawal or dismissal will be determined by campus policy. Contact the student health insurance office for more information.
5. Enrollment in the *plan* may be terminated for the reasons listed below. The student shall be notified in writing of the termination. Termination shall be effective no less than 30 days following the date of the written notice.
 - a. In regard to eligibility for UC SHIP, you knowingly provide material information that is false, or misrepresents information on any document or fail to notify the *plan administrator* of changes in your or your dependents' status.
 - b. You knowingly permit the use of your plan identification card by someone other than yourself or your dependents to obtain services; or
 - c. You knowingly obtain or attempt to obtain services under the *plan* by means of false, materially misleading, or fraudulent information, acts or omissions.

Enrollment in the *plan* may not be terminated on the basis of sex, race, color, religion, sexual orientation, ancestry, national origin, physical disability or disease status.

The Director of UC SHIP is responsible for the final decision on termination of enrollment in the *plan*.

6. If a registered student has been terminated from the *plan* and has no major medical health insurance coverage, as required by the

Regents of the University of California, the student health services staff will provide the student with assistance to find a health insurance plan that meets the University's minimum health benefit standards. Students may also contact coveredca.com to review Covered California exchange plans. The student is wholly responsible for the cost of any plan in which he or she enrolls and any medical care not covered under that plan, including costs of applying for coverage and plan premiums.

For dependents, coverage ends when the student's coverage ends, or when the *dependent* no longer meets the *dependent* eligibility requirements, whichever occurs first.

Important: If a marriage or domestic partnership terminates, or if a covered *child* loses dependent child status, the student must give or send Wells Fargo Insurance Services written notice of the termination and loss of eligibility status. Coverage for a former *spouse* or *domestic partner*, or dependent child, if any, ends when these individuals no longer meet eligibility criteria according to the "Eligible Status" provisions. If the *plan* suffers a loss because the student fails to notify Wells Fargo Insurance Services of the termination of their marriage or domestic partnership, or of the loss of a child's dependent status, we may seek recovery from the student for any actual loss resulting thereby. Failure to provide written notice to Wells Fargo Insurance Services will not delay or prevent termination of coverage for the *spouse*, *domestic partner* or *child*. If the student notifies Wells Fargo Insurance Services in writing to cancel coverage for a former *spouse*, *domestic partner* or *child*, if any, immediately upon termination of the student's marriage, domestic partnership or the *child's* loss of dependent child status, such notice will be considered compliant with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF BENEFITS AFTER TERMINATION.

Other Coverage Options after Termination. There may be other coverage options for you and/or your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as the plan of a *spouse* or *domestic partner*). You can learn more about many of these options at <https://www.healthcare.gov/>.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION WHICH DESCRIBES WHAT TYPES OR GROUPS OF PROVIDERS MAY FURNISH HEALTH CARE SERVICES OR SUPPLIES UNDER THE PLAN. 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.

Network Providers. The *plan* has made available to the *members* a network of various types of "*Network Providers.*" These providers are called "network" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called the Prudent Buyer Plan. *Network providers* have agreed to rates they will accept as reimbursement for covered services. The cost of benefits provided under this *plan* will generally be lower for *network providers* than for *out-of-network providers*. See the definition of "*Network Providers*" in the DEFINITIONS section for a complete list of the types of providers which may be *network providers*. **The University of California's five Health Systems, including hospitals, and other medical facilities, and affiliated professional providers have agreed to special discounted rates of reimbursement for UC SHIP members.**

A directory of *network providers* is available upon request. The directory lists all *network 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 customer service number listed on your identification card (ID card) and request that a directory be sent to you. You may also search for a *network provider* when you register as a member at www.anthem.com/ca. The listings include the credentials of the *claims administrator's network providers* such as specialty designations and board certification.

Out-of-Network Providers. *Out-of-network 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 *out-of-network providers* could be balance-billed by the *out-of-network provider* for those claims for services that are determined by the *claims administrator* as not payable

as a result of these review processes. Balance-billing practices must meet 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 *network 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 *network 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 Benefit Booklet. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover eligible expenses you incur for their services when they're practicing within their specialty. 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) or by the student health services. 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.

Centers of Medical Excellence and Blue Distinction Centers. The claims administrator provides access to *Centers of Medical Excellence (CME)* networks and *Blue Distinction Centers for Specialty Care (BDCSC)*. The facilities included in each of these 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* and *BDCSC* 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, BDCSC* or by a *UC Family* provider.**
- **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 *BDCSC* or by a *UC Family* provider.**

Benefits for services performed at a designated *CME* or *BDCSC* will be the same as for *network providers*. A *network provider* in the Prudent Buyer Plan network is not necessarily a *CME* or *BDCSC* 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. It is recommended:

- Before you leave home, call the customer service number on your ID card for coverage details.
- 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 and Claim Filing Information

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay at the time of service for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs you normally pay (non-covered services, deductible, co-payments, and co-insurance). The *hospital* should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay at the time of service for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating BlueCard Worldwide *hospital*. Then you must 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).
- BlueCard Worldwide 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.

- 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.

Note about UC Trips: The University provides a travel accident policy for students traveling on University business which is administered by the UC Office of the President at no additional cost to the students. For more information about this benefit and to register for the program, please go to:

<http://www.ucop.edu/risk-services/loss-prevention-control/travel-assistance/>

Please note that in order to receive emergency assistance abroad and utilize this benefit (which includes medical evacuation and repatriation of remains while working and researching in a foreign country on University business) you **MUST** register at the website listed above prior to your trip. Registration is simple and takes less than 5 minutes.

In all instances, the University of California Office of the President travel accident policy is primary and will pay benefits before the benefit provided under this *plan*.

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, MAKE IT MEDICALLY NECESSARY OR A COVERED SERVICE. CONSULT THIS BOOKLET OR TELEPHONE THE *CLAIMS ADMINISTRATOR* AT THE NUMBER SHOWN ON YOUR ID 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 should review the entire Benefit Booklet for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

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; or elective abortion. Call your prospective *physician* or clinic, or call the customer service telephone number listed on your ID card, to ensure that you can obtain the health care services that you need.

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*, subject 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 *network provider*. You may also ask your *physician* to refer you to a *network provider* to receive a second opinion. Most *UC Family* medical centers and professional providers offer discounted rates to UC SHIP members.

The coverage under this *plan* is secondary coverage to all other plans (including Medicare), except Medi-Cal, MRMIP and TRICARE, for any services not provided by the student health services. See EXCESS COVERAGE.

The benefits of this *plan* may be subject to the SUBROGATION AND REIMBURSEMENT section.

MEDICAL BENEFITS

DEDUCTIBLES

Benefit Year Deductible. All medical services and supplies received outside the student health services that are covered under this *plan* are subject to the *Benefit Year* Deductible listed below:

- Per Individual **\$200**
- Per Family..... **\$400**

There is an Individual or Family Pediatric Dental Deductible you must satisfy before the *plan* begins to pay for pediatric dental covered services. See PEDIATRIC DENTAL SERVICES:PEDIATRIC DENTAL DEDUCTIBLE for information (see page 30).

EXCEPTIONS: In certain circumstances, this deductible may not apply, as described below:

- The *Benefit Year* Deductible will not apply to the Medical Evacuation and Repatriation of Remains benefits.
- The *Benefit Year* Deductible will not apply to benefits for prescription drugs.
- The *Benefit Year* Deductible will not apply to services provided by a *network provider* that have a set-dollar Co-Payment, including office visits to *physicians, emergency* or urgent care, physical therapy, physical medicine, occupational therapy, speech therapy, chiropractic services, acupuncture, and osteopathic manipulation. However, the *Benefit Year* Deductible will apply to other charges made during an office visit, such as for testing procedures, surgery, and other services.
- The *Benefit Year* Deductible will not apply to benefits for *Preventive Care Services* when provided by a *network provider*.
- The *Benefit Year* Deductible will not apply to the following preventive immunizations provided by a *network provider*:
 - Diphtheria/Tetanus/Pertussis, administered together or individually
 - Measles, Mumps and Rubella
 - Varicella
 - Influenza
 - Hepatitis A and Hepatitis B, administered together or individually
 - Pneumococcal
 - Meningococcal

- Meningococcal B. The first injection in the series must be administered between the ages of 16 through 23.
- Anthrax
- BCG
- DTaP
- Hib
- Hib and DTP
- Japanese Encephalitis
- MMRV
- Rabies
- Smallpox
- Typhoid
- Yellow Fever
- Zoster
- Polio
- Human Papillomavirus [HPV] (female and male). The first injection in the series must be administered by age 27.

Note: Titer testing will be covered under the *Preventive Care Services* benefit (see page 64). Please see that provision for further details in MEDICAL CARE THAT IS COVERED.

This list is not exhaustive and is subject to change; see Anthem Blue Cross' Clinical Guidelines at www.anthem.com/ca for more information.

All other immunizations are subject to the *Benefit Year* Deductible.

- The *Benefit Year* Deductible will not apply to bariatric travel expenses incurred in connection with an authorized bariatric surgical procedure provided at a designated *BDCSC* or by a *UC Family* provider. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.
- The *Benefit Year* Deductible will not apply to Gender Reassignment Surgery travel expenses authorized by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.
- The *Benefit 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*, *BDCSC* or by a *UC Family* provider. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.
- The *Benefit Year* Deductible will not apply to diabetes education.

- The *Benefit Year* Deductible will not apply to telehealth services provided by a *physician* who is a *network provider*.

CO-INSURANCE, CO-PAYMENTS AND MAXIMUM MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

For Your Information

- **“Co-Insurance”** is the percentage of the *maximum allowed amount* which you are responsible to pay.
- **“Co-Payment”** is the set-dollar amount which you are responsible to pay.
- **“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. Medical expenses are incurred on the date you receive the service or supply.
- In addition to the Co-Insurance or 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 *out-of-network provider*.

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

- *Network Providers***10%**
- *Other Health Care Providers***10%**
- *Out-of-Network Providers***40%**

Exceptions:

- Your Co-Insurance for *out-of-network providers* will be the same as for *network providers* for the following services. You may be responsible for charges which exceed the *maximum allowed amount*.
 - Emergency services* provided by other than a *hospital*;
 - The first 48 hours of *emergency services* provided by a *hospital* (the *network provider* Co-Insurance will continue to apply to an *out-of-network provider* beyond the first 48 hours

if you, in the *claims administrator's* judgment, cannot be safely moved);

- c. The services of an *out-of-network provider* when Anthem approves a referral from a *physician* who is a *network provider* or from the student health services (see the provision AUTHORIZED CLAIMS ADMINISTRATOR REFERRAL on page 36);
 - d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist);
 - e. Clinical Trials; or
 - f. The services of an anesthesiologist and assistant surgeon who are *out-of-network providers* when the *hospital* where the surgery is to be performed, or *ambulatory surgical center*, AND the operating *physician* are BOTH *network providers*.
- Your Co-Payment will be **\$100** for *emergency room* services. This Co-Payment will not apply if you are admitted as a *hospital inpatient* immediately following *emergency room* treatment.
 - Your Co-Payment will be **\$50** for *urgent care* services provided by a *network provider*.
 - You are not required to pay Co-Insurance or a Co-Payment for the following services provided by a *network provider*:
 - a. Services or supplies provided under the *Preventive Care Services* benefit.
 - b. Home health care.
 - c. The following preventive immunizations:
 - Diphtheria/Tetanus/Pertussis, administered together or individually
 - Measles, Mumps and Rubella
 - Varicella
 - Influenza
 - Hepatitis A and Hepatitis B, administered together or individually
 - Pneumococcal
 - Meningococcal
 - Meningococcal B. The first injection in the series must be administered between the ages of 16 through 23.
 - Anthrax
 - BCG

- DTaP
- Hib
- Hib and DTP
- Japanese Encephalitis
- MMRV
- Rabies
- Smallpox
- Typhoid
- Yellow Fever
- Zoster
- Polio
- Human Papillomavirus [HPV] (female and male). The first injection in the series must be administered by age 27.

Note: Titer testing will be covered under the *Preventive Care Services* benefit (see page 64). Please see that provision for further details in MEDICAL CARE THAT IS COVERED.

This list is not exhaustive and is subject to change; see Anthem Blue Cross' Clinical Guidelines at www.anthem.com/ca for more information.

All other immunizations have a **10%** Co-Insurance.

- You will not be required to pay Co-Insurance for *medically necessary* air ambulance transportation. *Medically necessary* ground ambulance transportation has a **10%** Co-Insurance.
- Your Co-Payment for your first office visit for pregnancy care to a *physician* who is a *network provider* will be **\$15**. No Co-Payment will be required for subsequent office visits. 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, and other services.
- Your Co-Payment for each home visit by, or an office visit to, a *physician* who is a *network provider* and who is not a *specialist* (for other than pregnancy care), will be **\$15**. 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, and other services.

- Your Co-Payment for each home visit by, or an office visit to, a *specialist* who is a *network 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, and other services.
- Your Co-Payment for telepsych services provided by a *physician* who is a *network provider* will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Payment for telehealth services provided by a *physician* who is a *network provider* will be **\$20**. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Payment for the diabetes education program services provided by a *physician* who is a *network provider* will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Payment for chiropractic care, acupuncture services, rehabilitative care and habilitative services when provided by a *network provider* will be **\$20**. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Insurance for bariatric surgical procedures determined to be *medically necessary* and performed at a designated *BDCSC* will be the same as for *network providers*. **Services for bariatric surgical procedures are not covered when performed at other than a designated *BDCSC* or by a *UC Family provider*.** See UTILIZATION REVIEW PROGRAM.
NOTE: Co-Payments or Co-Insurance payments do not apply for bariatric travel expenses authorized by the *claims administrator*. Bariatric travel expense is available when the closest *BDCSC* is in excess of 50 miles from the *member's* residence.
- Your Co-Insurance for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated *CME* or *BDCSC* will be the same as for *network providers*. **Services for specified transplants are not covered when performed at other than a designated *CME, BDCSC* or by a *UC Family provider*.** See UTILIZATION REVIEW PROGRAM.

NOTE: Co-Payments or Co-Insurance payments do not apply for transplant travel expenses approved by the *claims administrator*. Transplant travel expense is available when the closest *CME* or *BDCSC* is more than 250 miles from the recipient or donor's residence.

- Your Co-Insurance for an authorized gender reassignment surgery performed at a facility approved by the *claims administrator* will be the same as for *network providers*. See UTILIZATION REVIEW PROGRAM.

NOTE: Co-Payments or Co-Insurance payments do not apply for travel expenses in connection with an authorized gender reassignment surgery performed at a facility which is designated by the *claims administrator* and approved for the gender reassignment surgery requested, provided the expenses are authorized by the *claims administrator*. (See UTILIZATION REVIEW PROGRAM for details.)

- You are not required to make a Co-Payment or Co-Insurance payment for the cost of services under the Medical Evacuation and Repatriation of Remains benefits up to the maximum payment amount for these services.
- Medical benefits while traveling out of the country are covered as follows:
 - a. Services provided by a *network provider* will be reimbursed at **90%** of the *maximum allowed amount*. You will be responsible for the remaining **10%** of the *maximum allowed amount*.
 - b. Services provided by an *out-of-network provider* will be reimbursed at **60%** of the covered billed charges. You will be responsible for **40%** of the remaining covered billed charges.
 - c. Services provided by an *other health care provider*, will be reimbursed at **90%** of the covered billed charges. You will be responsible for **10%** of the remaining covered billed charges.
- Your Co-Insurance for services provided under the Psycho-Educational Testing benefit will be **10%** of billed charges for *network* and *out-of-network providers*.

Co-Payment for Out-of-Network Hospital or Residential Treatment Center. All inpatient medical and behavioral health services and supplies are subject to the Out-of-Network Facility Inpatient Co-Payment

below when received at an out-of-network *hospital* or *residential treatment center*.

Out-of-Network Facility Inpatient Co-Payment \$500

EXCEPTIONS: In certain circumstances, this Co-Payment may not apply, as described below:

- The Out-of-Network Facility Inpatient Co-Payment will not apply to *emergency* admissions.
- The Out-of-Network Facility Inpatient Co-Payment will not apply to services for which Anthem Blue Cross has negotiated a single case payment agreement with the out-of-network facility.

Maximum Medical and Prescription Drug Out-of-Pocket Amount.

Your payments to meet your *Benefit Year* Deductible, Co-Insurance and Co-Payments for covered medical, pediatric dental, pediatric vision, and prescription drug expenses will apply to the out-of-pocket amounts listed below. Once you reach the out-of-pocket amount, you will no longer be required to pay Co-Insurance or make a Co-Payment for the remainder of that *Benefit Year*, but you remain responsible for any costs in excess of the *maximum allowed amount* or any Benefit Maximum.

Per Individual:

- *Network providers and other health care providers*..... **\$3,000**
- *Out-of-network providers*..... **\$6,000**

Per Family:

- *Network providers and other health care providers*..... **\$6,000**
- *Out-of-network providers*..... **\$12,000**

Pediatric dental services are subject to a different Out-of-Pocket Maximum amount. Once you meet the pediatric maximum, your pediatric dental services are covered 100%. The Pediatric dental maximum does apply to the medical out-of-pocket maximum. See PEDIATRIC DENTAL SERVICES:PEDIATRIC DENTAL OUT-OF-POCKET AMOUNT for information (see page 30).

Please Note: The maximum out-of-pocket amount for *network providers/other health care providers* and *out-of-network providers* are separate maximum out-of-pocket amounts. One does not accumulate toward satisfying the other.

- Expense incurred for non-covered services or supplies, or in excess of the *maximum allowed amount*, will not be applied toward your Maximum Medical and Prescription Drug Out-of-Pocket Amount, and is always your responsibility.

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-Insurance amount, and any benefit payment 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:

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
 - For transportation to the *BDCSC* or *UC Family Provider*.....up to **\$130** per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
 - For transportation to the *BDCSC* or *UC Family Provider*.....up to **\$130** per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
 - Hotel accommodationsup to **\$100** per day, for up to 2 days per trip or as *medically necessary*, limited to one room, double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)
 - Hotel accommodationsup to **\$100** per day, for up to 4 days, limited to one room, double occupancy

- For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)..... up to **\$25**
per day, for up to 4 days per trip

Fertility Preservation

- For all covered services..... **\$20,000**
during a member's lifetime
while covered under UC SHIP

Gender Reassignment Surgery Travel Expense

- For Each Surgical Procedure (limited to 6 trips)
 - For transportation to the facility where the surgery will be performed..... **\$250**
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room, double occupancy
 - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)..... **\$25**
per day,
for up to 21 days per trip

Hearing Aids

- For covered charges..... **One Hearing Aid**
per ear, every four years

Home Infusion Therapy

- For all covered services and supplies received during any one day **\$600***

*Maximum applies to *out-of-network providers* only

Medical Evacuation

- For all covered services..... **\$50,000**
maximum payment per trip

Psycho-Educational Testing

- For all covered services..... **\$3,000**
during a member's lifetime
while covered under UC SHIP

Repatriation of Remains

- For all covered services..... **\$25,000**

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
 - For transportation to the *CME, BDCSC* or *UC Family Provider*..... **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room,
double occupancy
 - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)..... **\$25**
per day for each person,
for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
 - For transportation to the *CME, BDCSC* or *UC Family Provider*..... **\$250**
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 7 days
 - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)..... up to **\$25**
per day, for up to 7 days per trip

PEDIATRIC VISION BENEFITS

CO-PAYMENTS. You can choose to have your eyewear services provided by network vision care providers or by out-of-network vision care providers; however, your benefits will be affected by this choice.

Members are covered until the last day of the month in which the individual turns nineteen (19) years of age. No referral is required for Pediatric Vision benefits covered under UC SHIP for members under age 19.

Network Vision Care Provider Co-Payments: There will be no Co-Payment required for services and supplies provided by a network vision care provider. Your cost for vision care services and supplies will be at discount prices.

Out-of-Network Vision Care Provider Co-Payments. There will be Co-Payment required for services and supplies provided by an out-of-network vision care provider; but, you will be responsible for any billed charge which exceeds the vision care *maximum allowed amount* as shown below.

Benefit	Network	Out-of Network
Routine Eye Exam – Once every <i>Benefit Year</i>	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$30
Comprehensive Low Vision Exam Once every five (5) <i>Benefit Years</i>	\$0 Co-Payment	Not covered
Low Vision Follow up Visits Up to four (4) visits in any five (5) <i>Benefit Years</i>	\$0 Co-Payment	Not covered
Optical/Non-optical Aids Up to one (1) per <i>Benefit Year</i>	\$0 Co-Payment	Not covered
Frames* (formulary) – Once every <i>Benefit Year</i>	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$45

Standard Plastic or Glass Lenses

- Once every *Benefit Year*
- The following lens options are included at no extra cost when received from *network providers*:
 - Transition lenses
 - Plastic photosensitive lenses
 - Polarized lenses
 - Standard polycarbonate
 - Factory scratch coating
 - UV coating
 - Anti-reflective coating (standard, premium or ultra)
 - Tint (fashion and gradient)
 - Oversized and glass-grey #3 prescription sunglass lenses
 - Blended segment lenses
 - Intermediate vision lenses
 - High index lenses

Single Vision	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$25
Bifocal	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$40
Trifocal	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$55
Lenticular	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$70
Progressive (standard, premium, select or ultra)	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$40

Contact Lenses*

- A (1) one year supply of contact lenses instead of eyeglass lenses

<ul style="list-style-type: none"> Fitting, evaluation, and follow-up care for both elective and non-elective contact lenses are included in the contact lens benefit 		
Elective (Conventional or Disposable) Lenses; or	\$0 Co-Payment, formulary	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$60
Non-Elective Contact Lenses	\$0 Co-Payment	\$0 Co-Payment up to a <i>maximum allowed amount</i> of \$40
<p>*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this SUMMARY OF BENEFITS.</p>		

PEDIATRIC DENTAL SERVICES

PEDIATRIC DENTAL DEDUCTIBLE

Benefit Year Deductible. All pediatric dental services and supplies that are covered under this *plan* are subject to the *Benefit Year* Deductible listed below. Members are covered until the last day of the month in which the individual turns nineteen (19) years of age. The network and out-of-network deductibles are combined.

- Per Individual **\$60**
- Per Family..... **\$120**

PEDIATRIC DENTAL OUT-OF-POCKET AMOUNT. After you have made the following total out-of-pocket payments for covered charges incurred during a *Benefit Year*, you will no longer be required to pay a Co-Payment or Co-Insurance for the remainder of that *Benefit Year*, but you remain responsible for costs in excess of the *maximum allowed amount*.

- Per Individual **\$1,000**
- Per Family..... **\$2,000**

Payment Rates. After the Pediatric Dental Deductible has been satisfied, the *plan* will pay the percentage of the *maximum allowed amount* shown below, for the type of services received, up to the *maximum allowed amount*.

Dental Services	Network	Out-of Network
Diagnostic & Preventive Services, for example: <ul style="list-style-type: none"> • Periodic oral exam • Teeth cleaning • Bitewing X-rays 	\$0 Co-Payment	\$0 Co-Payment
Basic Services Fillings, for example: <ul style="list-style-type: none"> • Amalgam (silver-colored) • Anterior (front) composite (tooth-colored) • Posterior (back) composite covered at amalgam allowance 	50% Co-Insurance	50% Co-Insurance

Endodontic Services , for example: <ul style="list-style-type: none"> • Root canal 	50% Co-Insurance	50% Co-Insurance
Periodontal Services , for example: <ul style="list-style-type: none"> • Scaling and root planning 	50% Co-Insurance	50% Co-Insurance
Oral Surgery Services	50% Co-Insurance	50% Co-Insurance
Major Services , for example: <ul style="list-style-type: none"> • Crowns 	50% Co-Insurance	50% Co-Insurance
Prosthodontic Services, for example: <ul style="list-style-type: none"> • Dentures • Bridges 	50% Co-Insurance	50% Co-Insurance
Dentally Necessary Orthodontic Services	50% Co-Insurance	50% Co-Insurance
Dentally Necessary Orthodontic Maximum	No Maximum	No Maximum
Cosmetic Orthodontic Services	Not covered	Not covered

NOTE: No referral is required for Pediatric Dental benefits covered under UC SHIP for members under age 19.

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 service under this *plan*. The *maximum allowed amount* is the total reimbursement payable under your *plan* for each covered service you receive from *network* and *out-of-network providers*. It is the *claims administrator’s* payment towards the services billed by your provider combined with any Deductible, Co-Insurance 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 an *out-of-network provider*, you may be billed by the provider for the difference between their charges and the *maximum allowed amount*. This is called *balance billing*. In many situations, this difference could be a significant out-of-pocket amount.

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

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

- The *member* receives services from a network surgeon. The billed charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member’s* Co-Insurance responsibility when a network 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 network surgeon accepts the total of \$1,000 as full reimbursement for the surgery regardless of the charges.

Example: The plan has a *member* Co-Insurance of 40% for *out-of-network provider* services after the Deductible has been met.

- The *member* receives services from an out-of-network surgeon. The billed charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member’s* Co-Insurance responsibility when an out-of-network surgeon is used is 40% of \$1,000, or \$400. The *plan* pays the remaining 60% of \$1,000, or \$600. In addition, the out-of-network surgeon could bill the *member* the difference between \$2,000 and \$1,000. So the *member’s* total out-of-pocket charge would be \$400 plus an additional \$1,000, for a total of \$1,400.

When you receive covered services, the *claims administrator* will, to the extent possible, 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 *network provider*, an *out-of-network provider* or *other health care provider*.

Network Providers. For covered services performed by a *network provider*, the *maximum allowed amount* for this *plan* will be the rate the *network provider* has agreed with the *claims administrator* to accept as reimbursement for the covered services. Because *network 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 or Co-Insurance. Please call the customer service telephone number on your ID card for help in finding a *network provider* or visit www.anthem.com/ca. This website displays all U.S. network providers. For travel abroad, please refer to the section titled CARE OUTSIDE THE UNITED STATES-BLUECARD WORLDWIDE.

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 *ambulatory surgical center* is licensed separately, you should find out if the facility is a *network provider* before undergoing the surgery.

Out-of-Network Providers and Other Health Care Providers. * For covered services you receive from an *out-of-network provider* or *other health care provider* the *maximum allowed amount* will be based on one of the following: 1) the applicable *out-of-network provider* rate or fee schedule for this *plan*; 2) an amount negotiated by the *claims administrator* or a third party vendor which has been agreed to by the

out-of-network provider; 3) an amount derived from the total charges billed by the *out-of-network provider*; or 4) an amount based on information provided by a third party vendor.

Unlike *network providers*, *out-of-network providers* and *other health care providers* may send you a bill and collect for the amount of the *out-of-network 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 *out-of-network provider* or *other health care provider* charges. This is often called *balance billing*. This amount can be significant. Choosing a *network 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 *network 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 an *out-of-network provider* or *other health care provider*.

ALERT: A network *hospital* may employ *out-of-network* health care providers. You should make sure the health care providers who will provide the services you need are *network providers*. You may be responsible for paying the difference between the *maximum allowed amount* and the amount the *out-of-network provider* charges.

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

***Exceptions:**

- **Ambulance Services.** The *maximum allowed amount* for ambulance services and supplies will be the billed charge.
- **Clinical Trials.** The *maximum allowed amount* for *out-of-network providers* for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *network 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 *network provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

3. By a *physician* who is an *out-of-network provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of the *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*.

WITH RESPECT TO YOUR MEDICAL BENEFITS

Reduction of The Maximum Allowed Amount for Non-Contracting Hospitals. A small percentage of hospitals which are *out-of-network 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 ID card to locate a *contracting hospital*.**

Emergency Services Provided by Out-of-Network Providers. *Out-of-network* providers may send you a bill and collect for the amount of the *out-of-network* provider's charge that exceeds the *maximum allowed amount* under this plan. You are responsible for paying the difference between the *maximum allowed amount* and the amount the *out-of-network* provider charges. This amount can be significant. If you receive a bill, please contact your campus student health services insurance office at 1-209-228-4876 for additional information or assistance. Covered *dependents* must contact the *claims administrator* at the phone number listed on their ID card for additional information or assistance.

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, Co-Insurance or Co-Payments). Your cost share amount may be different depending on whether you received covered services from a *network provider* (including *UC Family providers*) or *out-of-network provider*. Specifically, you may be required to pay higher cost-share amounts or may have limits on your benefits when using *out-of-network 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 *network provider* or *out-of-network 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 *network provider* cost share percentage when you use an *out-of-network provider*. For example, if you go to a network *hospital* or facility and receive covered services from an *out-of-network provider* such as a radiologist, anesthesiologist or pathologist providing services at the *hospital* or facility, you will pay the *network 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 *out-of-network provider's* charge, called "*balance billing*."

AUTHORIZED CLAIMS ADMINISTRATOR REFERRALS

In some circumstances the *claims administrator* may authorize *network provider* cost share amounts (Deductibles, Co-Insurance or Co-Payments) to apply to a claim for a covered service you receive from an *out-of-network 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 *network provider* cost share amount to apply to a covered service received from an *out-of-network provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *out-of-network provider's* charge. If you receive prior authorization for an *out-*

of-network provider due to network adequacy issues, you will not be responsible for the difference between the *out-of-network provider's* charge and the *maximum allowed amount*. Please call the customer service telephone number on your ID card for *authorized claims administrator referral* information or to request authorization.

DEDUCTIBLES, CO-INSURANCE, CO-PAYMENTS, MAXIMUM MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable deductible and your Co-Payment or Co-Insurance amount, the *plan* will pay benefits up to the *maximum allowed amount*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Co-Insurance, Maximum Medical and Prescription Drug 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. There is a separate combined network and out-of-network Pediatric Dental Deductible. Please see "Pediatric Dental Deductible" below for details.

Benefit Year Deductible. Each *year*, you will be responsible for satisfying the *Benefit Year* Deductible (see page 16) before benefits are paid. If members of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the *Benefit Year* Deductible for all family members will be considered to have been met.

Pediatric Dental Deductible. Each *year*, you will be responsible for satisfying the *Benefit Year* Deductible (see page 30) before benefits are paid. If members of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the *Benefit Year* Deductible for all family members will be considered to have been met. Your Pediatric Dental Deductible is a combination of covered services for both *network* and *out-of-network providers*.

CO-INSURANCE AND CO-PAYMENTS

The *claims administrator* will apply the applicable Co-Insurance percentage to the *maximum allowed amount* remaining after any deductible has been met. This will determine the dollar amount of your Co-Insurance.

For Co-Payment, the *claims administrator* will subtract your Co-Payment from the *maximum allowed amount*. Covered services requiring a Co-Payment are not subject to the *Benefit Year* Deductible.

Out-of-Network Facility Inpatient Co-Payment. Each time you are admitted to a *hospital* or *residential treatment center* which is an *out-of-network provider*, you are responsible for paying the Inpatient Co-Payment (see page 22). This Co-Payment will not apply to an *emergency* admission, or to services for which the *claims administrator* has negotiated a single case payment agreement with the out-of-network facility.

MAXIMUM MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

Satisfaction of the Maximum Medical and Prescription Drug Out-of-Pocket Amount. Your payments to meet your *Benefit Year* Deductible, Co-Insurance and Co-Payments for covered medical, prescription drug, pediatric dental, and pediatric vision expenses will apply to the out-of-pocket amounts. Once you reach the out-of-pocket amount, you will no longer be required to pay Co-Insurance or make a Co-Payment for the remainder of that *Benefit Year*, but you remain responsible for any costs in excess of the *maximum allowed amount* or any Benefit Maximum.

If enrolled *members* of a family pay amounts applied to Deductibles and Co-Payments and/or Co-Insurance in a *year* equal to the Out-of-Pocket Amount per family, the Out-of-Pocket Amount for all *members* of that family will be considered to have been met. Once the family Out-of-Pocket Amount is satisfied, no *member* of that family will be required to make Co-Payments or pay Co-Insurance for any additional covered services or supplies during the remainder of that *Benefit Year*, except as specifically stated under Charges Which Do Not Apply Toward the Out-of-Pocket Amount below. However, any expense previously applied to the Out-of-Pocket Amount per *member* in the same *year* will not be credited for any other *member* of that family.

Network Providers, Network Pharmacies and Other Health Care Providers. Only covered charges up to the *maximum allowed amount* for the services of a *network provider*, network pharmacy or *other health care provider* will be applied to the *network provider* and *other health care provider* Maximum Medical and Prescription Drug Out-of-Pocket Amount.

After this Out-of-Pocket Amount per *member* or family has been satisfied during a *Benefit Year*, you will no longer be required to pay Co-Insurance or make a Co-Payment for the covered services provided by a *network provider*, network pharmacy or *other health care provider* for the remainder of that *Benefit Year*. You will continue to be required to pay Co-Insurance or make a Co-Payment for the covered services of an *out-*

of-network provider or out-of-network pharmacy until the *out-of-network provider* Out-of-Pocket Amount has been met.

Out-of-Network Providers and Out-of-Network Pharmacies. Only covered charges up to the *maximum allowed amount* for the services of an *out-of-network provider* or out-of-network pharmacy will be applied to the *out-of-network provider* Maximum Medical and Prescription Drug Out-of-Pocket Amount. After this Out-of-Pocket Amount per *member* or family has been satisfied during a *Benefit Year*, you will no longer be required to pay Co-Insurance or make any Co-Payments for the covered services provided by an *out-of-network provider* or out-of-network pharmacy for the remainder of that *Benefit Year*.

Note: Any Co-Payments or Co-Insurance you pay toward your prescription drug benefit will apply towards your Maximum Medical and Prescription Drug Out-of-Pocket Amount as shown under in the SUMMARY OF BENEFITS. For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com/mycatamaranrx.

Charges Which Do Not Apply Toward the Maximum Medical and Prescription Drug Out-of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-of-Pocket Amount:

- Charges for services or supplies not covered under this *plan*; and
- Charges which exceed the *maximum allowed amount*.

MAXIMUM PEDIATRIC DENTAL OUT-OF-POCKET AMOUNTS. Your Pediatric Dental Out-of-Pocket Amount is a combination of covered services for both *network providers* and *out-of-network providers*. Once you reach the out-of-pocket amount, you will no longer be required to pay Co-Insurance or make a Co-Payment for the remainder of that *Benefit Year*. If enrolled *members* of a family pay amounts applied to Deductibles and Co-Payments and/or Co-Insurance in a *year* equal to the Out-of-Pocket Amount per family, the Out-of-Pocket Amount for all *members* of that family will be considered to have been met. Once the family Out-of-Pocket Amount is satisfied, no *member* of that family will be required to make Co-Payments or pay Co-Insurance for any additional covered services or supplies during the remainder of that *Benefit Year*.

MEDICAL BENEFIT MAXIMUMS

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

CONDITIONS OF COVERAGE

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

1. UC Merced does not require a referral from student health services, but students and dependents must receive a referral from a Primary Care Physician who is a *network provider* before seeking services of a *specialist*. Prior referral from a Primary Care Physician is not required for the services of a pediatrician, an obstetrician for pre-natal and maternity care, or a gynecologist.
2. 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.
3. The expense must be for a medical service or supply furnished to you as a result of illness, injury or pregnancy, except as specifically described in the section entitled MEDICAL CARE THAT IS COVERED.
4. 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.
5. 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*.
6. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
7. 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.
8. All services and supplies must be ordered by a *physician*.
9. The services or supplies must be *medically necessary*, unless the services are provided under the *Preventive Care Services* benefit.

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:

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.

Allergy. Allergy testing and *physician's* services. Allergy serum is covered when administered in a *physician's* office.

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.

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 unless transportation to a facility that is not the nearest facility is approved by the *claims administrator*.

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.

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.

Nonemergency: UC SHIP covers nonemergency ambulance and psychiatric transport van services if a *physician* determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger the your health. These services are covered only when the vehicle transports you to and from covered services.

Ambulance Services exclusion: Transportation by car, taxi, bus, gurney van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a covered service.

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

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at an approved *BDCSC* facility or by a *UC Family* provider. 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 *BDCSC* or by a *UC Family* provider will not be considered as covered under the plan.

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the *member's* home is fifty (50) miles or more from the nearest bariatric *BDCSC* or *UC Family provider*. All travel expenses must be approved by the *claims administrator* in advance. The fifty (50) mile radius around the *BDCSC* or *UC Family provider* will be determined by the *bariatric BDCSC* or *UC Family Provider coverage area*. (See DEFINITIONS.)

- Transportation for the *member* to and from the *BDCSC* or *UC Family provider* up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *BDCSC* or *UC Family provider* up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.

- Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *member's* initial surgery *stay*, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric *BDCSC* or *UC Family* provider. 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.

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.

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

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered under the *Preventive Care Services* benefit.
2. Breast cancer (BRCA) testing, if appropriate as determined by your physician, 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).

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

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

Chiropractic and Osteopathic Services. The following services provided by a *physician* under a treatment plan:

1. Services of a chiropractor for manual manipulation of the spine to correct subluxation;
2. Manipulation therapy services provided by an osteopath; and

Clinical Trials. Coverage is provided 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.

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

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

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

- i. The Department of Veterans Affairs,
 - ii. The Department of Defense, or
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
 3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your *physician* after determining participation has a meaningful potential to benefit you. You as a *member* may also submit a recommendation. You must provide medical and scientific information establishing that your participation in such a trial would be appropriate based upon meeting the *claims administrator's* required conditions.

All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to Anthem Clinical Coverage Guidelines, related policies and procedures.

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

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

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

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose

of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or to restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not considered an *accidental injury*.

Dental Services – Pediatric. The *plan* covers the following dental care services for members until the last day of the month in which the individual turns nineteen (19) years of age when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, the *plan administrator* will cover the least expensive.

Diagnostic and Preventive Services

- Oral evaluations (exams) – Initial and periodic
- Consultations – includes *specialist* consultations
- Radiographs (X-rays)
 - Bitewing x-rays in conjunction with periodic exams are limited to 1 series (4 films) in any 6-month period
 - Isolated bitewing or periapical films are allowed on an *emergency* or episodic basis
 - Full mouth x-rays in conjunction with periodic exams are limited to 1 in any 24-month period
 - Panoramic x-rays – limited to once in any 24-month period
- Dental cleaning (prophylaxis) – limited to 2 in any 12-month period. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth
- Topical application of fluoride or fluoride varnish
- Dental sealant treatments – Covered for first and second molars only
- Space maintainers (including acrylic and fixed band type)
- Preventive dental education and oral hygiene instruction

Basic Restorative Services

- Restorations (fillings) – covered as follows:
 - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries (decay). If the tooth can be restored with these materials, any other restoration, such as a crown, is considered an optional treatment
 - Composite resin or acrylic restorations on posterior (back) teeth is an optional treatment
 - Micro filled resin restorations that are non-cosmetic
 - Replacement of a restoration is covered only if it is defective, as evidenced by conditions such as recurrent decay or fracture
- Pins and pin build-up – covered only when given with a restoration
- Sedative base and sedative fillings
- Basic tooth extractions – including post-operative care such as exams, suture removal, and treatment of complications.
- Endodontic Services
- Direct pulp capping
- Therapeutic pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy – including culture canal, and retreatment of previous root canal therapy limited as follows:
- Retreatment of root canals covered only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit
- Apicoectomy
- Vitality tests

Periodontal Services

- Periodontal scaling and root planing, and subgingival curettage – limited to five quadrant treatments in any 12-month period
- Gingivectomy
- Osseous or muco-gingival surgery

Adjunctive General Services

- Local anesthetics. This is included as part of the restorative service; for example, a crown or filling.
- Oral sedatives and nitrous oxide – covered when dispensed in a dental office by a Provider acting within the scope of his or her licensure.

Oral Surgery Services

Oral surgery services include post-operative care such as exams, suture removal, and treatment of complications.

- Surgical extractions
- Removal of impacted teeth is covered only when evidence of pathology exists
- Biopsies of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus and mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Root recovery (separate procedure)
- General Anesthesia
 - Covered when given by a dentist for covered surgery services

Major Restorative Services

- Crowns – including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are covered as follows:
 - Replacement of each unit is limited to once in a 36-month period, except when crown is no longer functional
 - Acrylic crowns and stainless steel crowns are only covered for children through age 11. If other types of crowns are chosen for children through age 11, it will be considered an optional treatment
 - Crowns are covered only if there is not enough retentive quality left in the tooth to hold a filling
 - Veneers posterior to the second bicuspid are considered an optional treatment. We will pay up to the allowance for a cast full crown
- Recementation of crowns, inlays, and onlays
- Cast post and core, including cast retention under crowns
- Crown repair

Prosthetic Services

- Fixed bridges – bridges that are cast, porcelain baked with metal, or plastic processed to gold are covered as follows:

- Covered for persons age 16 and through age 18. Fixed bridges for persons under age 16 are considered optional treatment and will be covered up to the allowance for a space maintainer
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior (front) tooth
- Fixed bridges are covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an optional treatment
- Fixed bridges used to replace missing posterior teeth are considered optional treatment when the abutment teeth are sound and would be crowned only for the purpose of supporting a pontic
- Fixed bridges are considered optional treatment when provided in connection with a partial denture on the same arch
- Replacement of a fixed bridge is covered only if the existing bridge cannot be made satisfactory by repair

Note: We will cover up to 5 units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction and is an optional treatment.

- Recementation of bridges
- Repair or replacement of abutments or pontics
- Dentures – including full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers. Dentures are covered as follows:
 - Replacement for partial dentures is not covered within 36 months of initial placement unless:
 - It is necessary due to natural tooth loss where the addition or replacement of the existing partial is not possible; or
 - The denture is unsatisfactory and cannot be made satisfactory
 - Coverage for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen, and is not necessary to satisfactorily restore an arch, the patient is responsible for all additional charges
 - A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Any other treatments for these cases are considered optional treatments.
 - Full upper and/or lower dentures are not to be replaced within any 36-month period unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair

- Coverage for complete dentures will be limited to the benefit for a standard procedure. If a more personalized or specialized treatment is chosen, the patient will be responsible for all additional charges
- Chairside or laboratory relines or rebases – Covered one per arch in any 12-month period
- Denture repairs and adjustments
- Tissue conditioning – limited to two per denture
- Denture duplication
- Stayplates – Covered only when used as anterior space maintainers for children

Orthodontic Treatment

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. The *plan* will only cover orthodontic care that is *medically necessary*. You or your dentist should submit your treatment plan to the *claims administrator* before you start any orthodontic treatment to make sure it is covered under this *plan*.

Medically Necessary Orthodontic Care

Medically necessary services will be subject to review. To be considered *medically necessary*, the service must meet criteria for *medically necessary* care as established by the *claims administrator*. The *plan* will cover orthodontic care when it is *medically necessary* to prevent disease and promote oral health, restore oral structures to health and function, and treat *emergency* and urgent conditions.

Your dental provider should submit a prior authorization form to Anthem for this service. This form is available by calling the telephone number listed on Your ID Card or online at www.anthem.com/ca. You may call customer service at the telephone number listed on Your ID Card to ask that a prior authorization form be faxed to your dentist.

The prior authorization process is outlined below:

- The Dental Professional Review area handles the review.
- If the Anthem defined criteria is met, the Dental Professional Review area will communicate to the dentist and Insured about the approval.
- If the Anthem defined criteria is NOT met, the Dental Professional Review area will communicate to the dentist and Insured about the denial.
- The letters of response contain steps for additional review, including information about filing a grievance.

- If prior authorization is denied you have the right to file a grievance.

The following conditions automatically qualify for *medically necessary* orthodontic care.

- Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed *specialist* must be submitted, on his or her professional letterhead, with the prior authorization request.
- Craniofacial anomaly. Written documentation from a credentialed *specialist* shall be submitted, on his or her professional letterhead, with the prior authorization request.
- Deep impinging overbite when the lower incisors are destroying the soft tissue of the palate and tissue laceration or clinical attachment loss is present.
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present.
- Severe traumatic deviation such as loss of a premaxilla segment by burns or accident, the result of osteomyelitis, or other gross pathology. Written documentation of the condition must be submitted with the prior authorization request.
- Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

Orthodontic treatment may include the following:

- Limited Treatment – Treatments which are not full treatment cases and are usually done for minor tooth movement
- Interceptive Treatment – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment
- Comprehensive (complete) Treatment – Full treatment includes all radiographs, diagnostic casts/models, appliances and visits
- Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth
- Fixed Appliance Therapy – A component that is cemented or bonded to the teeth
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth

Note: Treatment in progress (appliances placed prior to being covered under this *plan*) will be considered for benefits on a pro-rated basis

Orthodontic Exclusions

Coverage is NOT provided for:

- Repair or replacement of lost/broken/stolen appliances if more than twenty-four (24) months have passed since date of service for orthodontic retention.
- If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.
- If the patient's orthodontic bands have to be temporarily removed and then replaced due to a Medical Necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating Physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. The covered individual must have continuous coverage under this *plan* in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: 1. when treatment begins (appliances are installed), and 2. at six (6) month intervals thereafter, until treatment is completed or this coverage ends.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated maximum allowed amount, including any amount (Co-Insurance) you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of appliance placement and his/her signature. After benefit and eligibility verification by us, a payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted six (6) months from the date of appliance placement.

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

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

3. The following items are covered as medical supplies:
 - a. Insulin syringes and disposable pen delivery systems for insulin administration. **NOTE:** Charges for insulin and other prescriptive medications are not covered as part of your medical plan. See your pharmacy benefits plan booklet for information on prescriptive medications.
 - b. Testing strips, lancets and alcohol swabs.

4. Screenings for gestational diabetes are covered under your *Preventive Care Services* benefit. Please see that provision for further details.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

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

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

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

Fertility Preservation. Covered services for *medically necessary* fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility. These medical treatments may include chemotherapy, hormone therapy, radiation, surgery or other medications that are determined to incur the risk of *infertility*. Covered services under the *plan* are as follows:

- Standard fertility preservation treatments and collection identified by appropriate professional societies such as the American Society of Reproductive Medicine or American Society of Clinical Oncology
- Embryo freezing and egg freezing: medications, doctors' fees, anesthesia costs, infectious disease testing and laboratory procedures
- Sperm freezing
- Infectious disease lab testing for reproductive material storage
- Reproductive material storage for the duration of membership in the UC SHIP plan only; storage expenses are no longer covered when the *member* leaves
- Surgical procedures related to fertility preservation services*
- Radiation shielding
- Prescription drugs that are pertinent to fertility preservation services

If the services are authorized (See UTILIZATION REVIEW PROGRAM for details), this *plan* will provide *medically necessary* benefits in connection with fertility preservation. The plan's maximum payment will not exceed **\$20,000** during the member's lifetime while covered under UC SHIP.

The following procedures are investigational in men/women and adolescent boys/girls and therefore not covered.

- In vitro maturation of oocytes
- Ovarian tissue cryopreservation and transplantation procedures
- Testicular tissue or spermatogonial cryopreservation and transplantation or testis xenografting
- Testicular suppression with gonadotropin-releasing hormone (GnRH) analogs or antagonists.
- Ovarian suppression with Gonadotropin Releasing Hormone (GnRH) analogs or antagonists.

Gender Reassignment Surgery Benefits. This *plan* provides benefits to insured members for many of the charges incurred for gender reassignment surgery. Not all charges are eligible and some are only eligible to a limited extent. Gender reassignment surgery must be performed at a facility designated and approved by the *claims administrator* for the type of gender reassignment surgery requested and must be authorized prior to being performed. **Charges for services that are not authorized, or which are provided in a facility other than the one which the *claims administrator* has designated and approved for the gender reassignment surgery requested, will not be considered covered under the *plan*.** See UTILIZATION REVIEW PROGRAM for details.

If the services are authorized (See UTILIZATION REVIEW PROGRAM for details), this *plan* will provide *medically necessary* benefits in connection with gender reassignment surgery.

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

- a. Round trip coach airfare to the facility which is designated by the *claims administrator* and approved for the gender reassignment surgery requested, not to exceed **\$250** per person per trip;
- b. Hotel accommodations, not to exceed **\$100** per day for up to 21 days per trip, limited to one room, double occupancy; and

- c. Other reasonable expenses, not to exceed **\$25** per day for each person, for up to 21 days per trip.

Genetic Testing. Genetic testing for individuals to assess their risk for a variety of conditions. **Note:** Testing is only available according to the *claims administrator's* clinical guidelines.

Habilitative Services. Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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.

Covered charges under 2 and 3 above for hearing aids are limited to one hearing aid per ear, every four years.

These items and services are covered under your *plan's* benefits for durable medical equipment (see Durable Medical Equipment and Prosthetic Devices).

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).

NOTE: Hearing aids are not covered if provided by an *out-of-network provider*.

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

The following renal dialysis services are covered:

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

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

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*.

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 pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

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, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), 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 including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.
6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Please note: Only specified *network providers* have been approved by the *claims administrator* to provide medications to treat hemophilia. To find an approved *network provider* who can provide medications to treat hemophilia, please call the toll-free number printed on your identification card if you have any questions about making this determination. *Drugs* to treat hemophilia that you receive from a provider other than a *network provider* approved by the *claims administrator* will be considered *out-of-network provider* charges subject to the cost shares and any limitations associated with those services.

With respect to home infusion therapy benefits, the *plan's* maximum payment will not exceed **\$600** for the services or supplies received during any one day when provided by a home infusion provider which is not a *network provider*.

Home infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

Hospice Care. The *plan* will pay for:

1. Room and board charges in an inpatient *hospice* unit;
2. Services of a registered nurse, licensed practical nurse and licensed vocational nurse;
3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy;
4. Medical social services;
5. Services of a home health aide;
6. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation;
7. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*;
8. Medical supplies;
9. Oxygen and related respiratory therapy supplies;
10. Bereavement counseling for your family; and
11. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

Hospital. Covered services under the *plan* are as follows:

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

Immunizations. Preventive immunizations provided by a *network provider* are covered under this *plan*. Please see the SUMMARY OF BENEFITS section for a list of preventive immunizations.

This list is not exhaustive and is subject to change; see Anthem Blue Cross' Clinical Guidelines at www.anthem.com/ca for more information.

Jaw Joint Disorders. The *plan* 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.

Medical Evacuation. For *members* who are studying or traveling abroad or international students in the U.S. on a non-immigrant visa, benefits will be paid toward reimbursement of the expenses incurred transporting you back to your country of legal residence for medical care and treatment. The *plan* will pay medical evacuation benefits if: (a) your illness commenced or injury occurred while you were covered by this *plan*; (b) your *physician* certifies in writing that you are medically stable and you require further care and treatment for your accident or illness; and (c) you have incurred expenses for your transportation back to your country of legal residence for your medical care and treatment. The total amount of benefit for medical evacuation is **\$50,000**.

Benefits will not be paid under this *plan* for expenses incurred for or in connection with the following:

1. Services for medical evacuation when you have mild lesions, simple injuries such as sprains, simple fractures, or mild illness which can be treated in the country where you are studying or traveling and do not prevent you from participating in your studies;
2. Services for medical evacuation when your *physician* does not certify, in writing, that you need further medical care or treatment for an illness or accident that has commenced or has occurred while traveling or studying abroad; and
3. The cost of airfare for a family member or traveling companion accompanying you.

Mental or Nervous Disorders or Substance Use Disorders. Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance use disorders.

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.

3. *Physician* visits during a covered inpatient *stay*.
4. Outpatient medication management by a psychiatrist.
5. *Physician* visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care for the treatment of *mental or nervous disorders* or substance use disorders.
6. Counseling for the treatment of anorexia nervosa or bulimia nervosa.
7. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.
8. Services related to narcotic maintenance therapy such as methadone maintenance therapy.
9. Group therapy or counseling.

Treatment for substance use disorder does not include smoking cessation programs.

Neuropsychological Testing. Neuropsychological testing by a neuropsychologist.

Nutrition and Counseling. Services and supplies provided for *medically necessary* dietary and nutritional evaluations, counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa.

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

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

1. Nebulizers, including face masks and tubing, inhaler spacers and peak flow meters.

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

Pediatric Dental Services

Please see "Dental Services."

Pediatric Vision Services

Please see "Vision Services."

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

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultraviolet 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 physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.
3. Outpatient speech therapy following injury or organic disease.

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.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy in the following situations: (a) mother is age 35 or over at the time of delivery; or (b) family history of chromosomal anomaly; or (c) previous *child* of *member* was delivered with chromosomal anomaly; or (d) high or low serum alpha-fetoprotein.

Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.

2. All covered services for the newborn *child's* first 31 days after birth will be covered at the benefit level of the *student* provided Anthem Blue Cross has been notified of the *child's* birth. If the *child* is not enrolled as a covered *dependent* within 31 days of birth, benefit coverage will end.

Note: The student must notify Wells Fargo Insurance Services of the *child's* birth within 31 days of birth to enroll them as a *dependent*. Their Customer Care telephone number is 1-800-853-5899.

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

Preventive Care Services. Screening services and supplies provided in connection with *preventive care services* as shown below. The *Benefit Year* Deductible will not apply to these services or supplies when they are provided by a *network provider*. No Co-Insurance or Co-Payment will apply to these services or supplies when they are provided by a *network provider*.

1. A *physician's* services for *routine physical examinations*.
2. Immunizations prescribed by an examining *physician* related to *preventive care services*.
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 as determined by your *physician* (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV); prostate cancer; colorectal cancer; and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. All FDA-approved contraceptive *drugs*, devices and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive *drugs*, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the *drugs*, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

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

In order to be covered as preventive care, contraceptive prescription drugs must be generic. For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com/mycatamaranrx.

- b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.
 - c. Gestational diabetes screening.
 - d. Preventive prenatal care.
8. Preventive services for certain high-risk populations as determined by your *physician*, based on the *physician's* clinical expertise.
9. Tuberculosis (TB) Screening as part of an annual preventive physical examination for members. This service is available at no cost for students only at the student health services on campus. Covered dependents may seek services off campus.
10. Titer laboratory tests to measure the level of antibodies for a specific disease. Immunization titers may be performed to determine if a *member* should have a vaccination.

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 Co-Payment and will not apply to the *Benefit Year Deductible*.

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

Professional Services

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

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; and shoe inserts that are custom molded to the patient.

Psycho-Educational Testing. Psycho-educational testing will be covered when conducted by a neuropsychologist, or licensed clinical, educational, or counseling psychologist in order to assess and diagnose functional limitations due to learning disabilities. This benefit covers psycho-educational test batteries including aptitude, achievement, and cognitive tests to assess for cognitive and learning disabilities; a written report listing test scores, testing procedures followed, interpretation of test results, and date(s) of testing. Consultation with the *member* to review test results and recommendations for appropriate academic accommodation are also covered under this benefit. Limited to **\$3,000** for the *member's* lifetime while covered by UC SHIP.

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

Reconstructive Surgery. 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.

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

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

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 separate prescription drug benefit. For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com/mycatamaranrx. Special food products that are not available from your prescription drug benefit plan are covered as medical supplies under this *plan's* medical benefits.

Sterilization. Sterilization including female tubal ligation and male vasectomy.

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.

TelePsych Services. This *plan* provides benefits for covered services that are appropriately provided through telepsychiatry, 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. “Telepsychiatry” is the application of telemedicine to the specialty field of psychiatry. The term typically describes the delivery of psychiatric assessment and care through videoconferencing.

Therapeutic/Elective Abortion. Therapeutic and elective termination of pregnancy, including Mifepristone when provided under the Food and Drug Administration (FDA) approved treatment regimen.

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 own coverage.
- 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.

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. Call the customer service phone number on the back of your ID card and ask for the transplant coordinator. 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)* or *Blue Distinction Centers for Specialty Care (BDCSC)* or UC Family provider rules, or exclusions apply.

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. Failure to obtain 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 collection 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 collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or collection 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)*, *Blue Distinction Centers for Specialty Care (BDCSC)*

or *UC Family provider*. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME, BDCSC or a UC Family provider will not be considered covered.** Call the toll-free telephone number for pre-service review on your ID 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, BDCSC* or *UC Family provider*. See UTILIZATION REVIEW PROGRAM for details.

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

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
 - a. Round trip coach airfare to the *CME, BDCSC* or *UC Family provider*, not to exceed **\$250** per person per trip.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 21 days per trip, limited to one room, double occupancy.
 - c. Other reasonable expenses (excluding meals, tobacco, alcohol and drug expenses), not to exceed **\$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
 - a. Round trip coach airfare to the *CME, BDCSC* or *UC Family provider*, not to exceed **\$250**.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 7 days.
 - c. Other reasonable expenses (excluding meals, tobacco, alcohol and drug expenses), not to exceed **\$25** per day, for up to 7 days.

Tuberculosis Screening and Testing. Services and supplies provided in connection with tuberculosis screening and testing when the screening/testing is prescribed by your *physician*. Services include, but are not limited to, tuberculosis screenings, chest physical exams, skin tests, and chest x-rays.

Vision Services – Pediatric. The following vision care benefits are available to members until the last day of the month in which the individual turns nineteen (19) years of age. The *plan* will cover vision care that is listed in this section.

Routine Eye Exam

The *plan* covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

The following lens options are included at no extra cost when received from a *network provider*:

- Transition lenses
- Plastic photosensitive lenses
- Polarized lenses
- Standard polycarbonate
- Factory scratch coating
- UV coating
- Anti-reflective coating (standard, premium or ultra)
- Tint (fashion and gradient)
- Oversized and glass-grey #3 prescription sunglass lenses
- Blended segment lenses
- Intermediate vision lenses
- High index lenses

Covered eyeglass lenses include standard plastic (CR39) or glass lenses up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive
- lenticular

Frames

- Frames are limited to once every *Benefit Year*

Elective Contact Lenses

- A one (1) year supply of contact lenses is covered every *Benefit Year*
- Coverage includes fitting, evaluation, and follow-up care for both elective and non-elective contact lenses (see below)
- Elective contact lenses are contacts that you choose instead of eyeglasses for comfort or appearance. You may choose elective contact lenses in lieu of your eyeglass lenses benefit.

Non-Elective Contact Lenses

- Non-elective contacts may be *medically necessary* and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Non-elective contact lenses are provided when *medically necessary*, including but not limited to the following conditions:
 - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses, pathological myopia, aphakia, Anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism
 - High Ametropia exceeding -12D or +9D in spherical equivalent
 - Anisometropia of 3D or more
 - Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

Note: If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the SUMMARY OF BENEFITS.

Low Vision

Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices and provide training instruction to maximize the remaining usable vision for *members* with low vision.

Low vision benefits include:

- Comprehensive Low Vision Exam
- Optical/Non-optical aids, including items such as high-power spectacles, magnifiers and telescopes
- Supplemental testing and follow-up care (up to four visits in any five year period)

BENEFITS FOR PERVASIVE 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, co-insurance, and co-payments 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, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

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

The *claims administrator's* network of *network providers* is limited to licensed Qualified Autism Service Providers who contract with the *claims 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 the *claims administrator* upon request.

REPATRIATION OF REMAINS EXPENSE COVERAGE

REPATRIATION OF REMAINS ELIGIBILITY

Benefits are payable under this coverage if:

1. The *insured student's* or *dependent's* country of permanent legal residence is not the United States and you die from any cause while in the United States; or
2. You are an *insured student or dependent* who is a legal United States resident outside of the United States and you die from any cause while outside of the United States.

REPATRIATION OF REMAINS EXPENSE

The *plan* will pay expenses incurred to meet the minimum legal requirements for transportation of human remains, up to the Maximum Amount of Coverage, to prepare and transport your remains from the United States to the country of your permanent legal residence, or, if you are a permanent legal resident of the United States, from the country in which you are traveling to the United States, subject to the following:

CONDITIONS FOR BENEFITS

The *plan* will pay benefits if your death occurs under these conditions:

1. Your death occurred while you were insured by this coverage;
2. Your death occurred:
 - For a student or *dependent* whose country of permanent legal residence is not the United States, while you were in the United States; or
 - For a student, or *dependent* who is a legal United States resident, while traveling outside the United States; and
3. One or more persons have incurred expense for the preparation and transportation of your remains to your country of legal residence for burial.

Maximum Amount of Coverage \$25,000

EXCLUSIONS

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 Covered. Services received before your *effective date*.

Preparation and Transportation of Remains within the U.S. For a student or *dependent* who is a legal United States resident and dies within the United States, services furnished to prepare and transport your remains within the United States.

Travel Expense. Transportation of anyone accompanying the body to the country of legal residence, or traveling for the purpose of visitation.

Funeral Expenses. The cost of a funeral, including, but not limited to, a viewing or visitation and formal funeral service, use of a hearse to transport the body to the funeral site and cemetery, and burial entombment.

Embalming and Cremation. The cost of embalming (unless legally required); the cost of cremation of remains.

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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.

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

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.

Cost-Shares Waived by an Out-of-Network Provider. The *plan* will not cover any cost-shares, such as a co-payment or a deductible, for which you are responsible to pay under the terms of this *plan*, when the cost-share is waived by an *out-of-network provider*.

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

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* 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.

Dental Services or Supplies (For age 19 and over). For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

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

This exclusion does not apply to the following:

- Services which we are required by law to cover;
- Services specified as covered in the section MEDICAL CARE THAT IS COVERED;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

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

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

7. Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

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

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

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

Eyeglasses/Contact Lenses. For prescription, fitting, or purchase of eyeglasses or contact lenses unless specifically stated as a covered service in this *plan* or as required by law. Items and services such as eye surgery or contact lenses to reshape the eye for purposes of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition. This exclusion applies except for services specified as covered in the section MEDICAL CARE THAT IS COVERED.

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 eye glasses required as a result of this surgery.

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.

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

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.

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

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

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

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

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

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined in the DEFINITIONS section of this Booklet.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services. Some services not specifically listed may be covered under the Plan. Please call the customer service telephone number on your ID card for more information.

Optometric Services or Supplies (For age 19 and over). Optometric services are covered under a separate Vision Plan (see the Blue View Vision Plan Booklet, available at your student health services or on the *plan* website). Eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under *Preventive Care Services* provision of MEDICAL CARE THAT IS COVERED. Eye glasses or contact lenses, except as specifically stated in the Prosthetic Devices provision of MEDICAL CARE THAT IS COVERED.

Orthodontic Services. This includes dental braces, other orthodontic appliances and any related service unless specifically stated as a covered service. This exclusion does not apply to members up to age 19 or with cleft palate conditions.

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated under the Home Infusion Therapy and Therapeutic/Elective Abortion provisions of MEDICAL CARE THAT IS COVERED section. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids. See your pharmacy benefits plan booklet for information on outpatient prescription drugs, medication and insulin. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED, are covered, subject to all terms of this *plan* that apply to that benefit.

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

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

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

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

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

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

Sports Related Conditions. Expenses incurred for injury resulting from the play or practice of intercollegiate sports. This exclusion does not apply to intramural or club sports. This exclusion also does not apply to the extent that a student has incurred medical expenses that are not covered due to either

(1) the maximum per-injury limits of insurance coverage provided by the National Collegiate Athletic Association (NCAA) or the National Association of Intercollegiate Athletics (NAIA); or

(2) a specific limitation or exclusion in such NCAA or NAIA coverage, or any other coverage provided by the UC athletic department for medical expenses incurred in the play or practice of intercollegiate sports, for an expense that is otherwise eligible under UC SHIP.

In combination with insurance/benefits provided by UC athletic departments, this provision assures that intercollegiate athletes do not incur any out-of-pocket expense resulting from the practice or play of NCAA- or NAIA-sanctioned intercollegiate sports.

Sterilization Reversal. Reversal of sterilization.

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

Teeth (Congenital Anomaly). Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this *plan* under “Pediatric Dental Services” or as required by law. This exclusion does not apply to members under the age 19.

Teeth, Jawbone, Gums. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a covered service under “Pediatric Dental Services.”

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine, except as specifically provided under the Telehealth/Telepsych Services provisions in the MEDICAL CARE THAT IS COVERED section.

Vision care: The *plan* will not pay for services incurred for, or in connection with, any of the items below.

- For which the *member* has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the *member's* immediate family, including *spouse, domestic partner, child, brother, sister* or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.

- For missed or canceled appointments.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a *network provider*).
- For safety glasses and accompanying frames.
- For inpatient or outpatient *hospital* vision care, unless covered by the medical benefits of this *plan*.
- For orthoptics or vision training.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this *plan*.
- Lost or broken lenses or frames, unless the *member* has reached the member's normal interval for service when seeking replacements.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames purchased outside of the *plan's* formulary.

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

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

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

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* or its delegate 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.

EXCESS COVERAGE

We will reduce the amount payable under this *plan* to the extent expenses are covered under any other plan. The *claims administrator* will determine the amount of benefits provided by other plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. Coordination of benefits will apply to Pediatric Dental benefits only. The amount from other plans includes any amount to which the *member* is entitled, whether or not a claim is made for the benefits. This *plan* is secondary coverage to all other policies except Medi-Cal, MRMIP, and TRICARE.

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.

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

UTILIZATION REVIEW REQUIREMENTS AND EFFECT ON BENEFITS

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.

The appropriate utilization reviews must be performed in accordance with this *plan*. 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:

- Admissions to a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense if:
 - ◆ The services are to be performed for the treatment of morbid obesity;
 - ◆ 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
 - ◆ The bariatric surgical procedure will be performed at a *BDCSC* facility or by a *UC Family* provider.
- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.
- Fertility preservation and related covered services.
- Gender reassignment surgery benefits and related covered services will be provided as follows:
 - ◆ The Surgical Procedure:
 - The services are *medically necessary* and appropriate; and
 - The *physicians* on the surgical team and the facility in which the surgery is to take place are approved for the gender reassignment surgery requested.
 - ◆ Gender Reassignment Surgery Travel Expense:
 - It is for gender reassignment surgery and related services, authorized by the *claims administrator*; and
 - The gender reassignment surgery must be performed at a specific facility designated by the *claims administrator* which is approved for the gender reassignment surgery requested.
- Home health care. The following criteria must be met:
 - ◆ The services can be safely provided in your home, as certified by your attending *physician*;
 - ◆ Your attending *physician* manages and directs your medical care at home; and
 - ◆ 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*.

- Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions.

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

- ◆ Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- ◆ Mastectomy in association with a breast cancer diagnosis and lymph node dissection.
- 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.
- Transplant services including transplant travel expense. The following criteria must be met for certain transplants, as follows:
 - ◆ 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.
 - ◆ 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)*, *Blue Distinction Centers for Specialty Care (BDCSC)* facility or by a *UC Family* provider.

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.**

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 for medical necessity 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.

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

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, benefits will not be provided, as shown in the “Utilization Review Requirements and Effect on Benefits” section.

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 three working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *network providers* will initiate the review on your behalf. An *out-of-network 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 ID 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 *network providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask an *out-of-network provider* to call the toll free number printed on your ID card or you may call directly.

3. When it is determined that the service is *medically necessary* and appropriate, the *claims administrator* 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 it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. You and your *physician* will receive written notice within two business days following the 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 the *claims administrator* 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 is 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.

DECISION AND NOTICE REQUIREMENTS

The *claims administrator* will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, the *plan* will follow state laws. If you live in and/or get services in a state other than the state where your *plan* was issued, other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	Timeframe Requirement for Decision
Pre-service urgent	72 hours from the receipt of the request
Pre-service non-urgent	5 business days from the receipt of the request
Care coordination review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Care coordination review urgent when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Care coordination review urgent when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Care coordination review non-urgent	5 business days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, the *claims administrator* will follow state and federal law and tell the requesting *physician* and send written notice to you or your authorized representative of the specific information needed to finish the review. If the *plan* does not get the specific information it needs or if the information is not complete by the timeframe identified in the written notice, the *claims administrator* will make a decision based upon the information received.

The *claims administrator* will give notice of a decision as required by state and federal law. Notice may be given by the following methods:

- **Verbal:** Oral notice given to the requesting *physician* by phone or by electronic means if agreed to by the *physician*.
- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting *physician* and you or your authorized representative.

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;
- You have exceeded limits under this *plan*; or
- You are not eligible for coverage when the service is actually provided.

Revoking or modifying an authorization. A certification 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 *plan* terminates;
- You reach a benefit maximum that applies to the services in question; or
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

For a copy of the medical necessity review process, please contact customer service at the telephone number on the back of your identification card.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual 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* does not have an obligation to provide individual case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

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

Participation in Case Management is confidential and voluntary, and is made available at no extra cost to you. Case Management is provided by, or on behalf of and at the request of, your health plan case management staff.

If you meet program criteria and agree to take part, then the *claims administrator* will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

In addition, the *claims administrator* may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, the *plan* may provide benefits for alternate care that is not listed as a covered service. The *claims administrator* may also extend services beyond the benefit maximums of this *plan*. A decision will be made case-by-case, if in the *claims administrator's* discretion the alternate or extended benefit is in the best interest of the *member* and the *plan*. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The *claims administrator* reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the *claims administrator* will notify you or your authorized representative in writing.

Medically Necessary Orthodontic Care (for members under age 19).

Before you receive *medically necessary* orthodontic care, your dental provider should submit a prior authorization form to Anthem for this service. This form is available by calling the telephone number listed on your ID Card or online at www.anthem.com/ca. You may call customer service at the telephone number listed on Your ID Card to ask that a prior authorization form be faxed to your dentist.

The prior authorization process is outlined below:

- The Dental Professional Review area handles the review.
- If the Anthem defined criteria are met, the Dental Professional Review area will communicate to the dentist and Insured about the approval.
- If the Anthem defined criteria are NOT met, the Dental Professional Review area will communicate to the dentist and *member* about the denial.
- The letters of response contain steps for additional review, including information about filing a grievance.
- If prior authorization is denied, you have the right to file a grievance as outlined in the COMPLAINT NOTICE.

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 of Anthem Blue Cross Life and Health 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.

The *claims administrator* 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, 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*.

CONTINUATION OF BENEFITS AFTER TERMINATION

If a *member* is confined as an inpatient in a *hospital* on the date of termination of the *plan* or when coverage would otherwise terminate, benefits may be continued for treatment of illness or injury for which the *member* is hospitalized. No benefits are provided for services treating any other illness, injury or condition. The *member's* benefits will be extended for a period of 30 days provided that the *member* is confined as an inpatient in a *hospital*, under a *physician's* care, and the services are *medically necessary*. Any benefits payable under this *plan* will not exceed any benefit maximums shown under the section entitled SUMMARY OF BENEFITS: MEDICAL BENEFIT MAXIMUMS.

GENERAL PROVISIONS

Providing of Care. The *plan administrator* is 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 the *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 *network 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/or 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/or 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 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.

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.

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.

Protection of Coverage. This *plan* does not have the right to cancel your coverage while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required premiums are paid according to the terms of the *plan*, except as noted under the terms of HOW COVERAGE ENDS.

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*.

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 *network 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. The *plan* is 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 the *claims administrator* properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. The *plan* is not liable for the benefits of the *plan* if you do not file claims within the required time period. The *plan* will not be liable for benefits if the *claims administrator* does not receive written proof of loss (a completed claim form) on time.

Members must submit a completed claim form including name, address, member ID number (as shown on their UC SHIP Medical ID card) along with supporting documents such as a clear copy of the detailed bill (provider name, address, tax ID, date(s) of service, individual/total charge(s), procedure and diagnosis codes) as well as receipts to prove the expenses were incurred.

Payment to Providers. The benefits of this *plan* will be paid directly to contracting hospitals, *network providers* and medical transportation providers. If you receive services from *non-contracting hospitals* or *out-of-network providers*, payment may be made directly to the student and you will be responsible for payment to the provider. In some cases an *out-of-network provider* may be willing to submit claims on behalf of the member to the *claims administrator*, in which case the student would have to sign a statement assigning benefits to the provider. The *plan* will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your covered *dependents*. The *plan* will continue such direct payment until the *emergency care* results in stabilization. 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, 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 an audit 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.

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

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided services 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 premium or other terms of the *plan* may be changed from time to time.

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a provider who was a member of your *prior plan's* network but is an *out-of-network provider* under this *plan*. 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 *out-of-network 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 dependent 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* 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 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*.

You will be notified 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, co-insurance, and co-payments under the *plan*. Financial arrangements with *out-of-network providers* are negotiated on a case-by-case basis. The *out-of-network provider* will be asked to agree to accept reimbursement and contractual requirements that apply to *network providers*, including payment terms. If the *out-of-network provider* does not agree to accept said reimbursement and contractual requirements, the *out-of-network provider's* services will not be continued. 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 *network provider* level for covered services (subject to applicable co-payments, co-insurance, 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 *network 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, including reimbursement rate, of 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 covered at the *network provider* benefit level 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 dependent 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 will be notified 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, co-insurance, and co-payments 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 *network 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 continue to be reimbursed at the *network provider* level. If you disagree with the determination regarding continuity of care, you may file complaint as described in the COMPLAINT NOTICE.

DEFINITIONS

The meanings of key terms used in this Benefit Booklet are shown below. Whenever any of the key terms shown below appears, it will appear in italicized letters. When any of the terms below are italicized in this Benefit 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 claims administrator referral is required when, because of your medical needs, you require the services of a *specialist* who is an *out-of-network provider*, or you require special services or facilities not available at a *contracting hospital*. Network-level benefits will apply only when the referral has been authorized by the *plan administrator* before services are rendered and when the following conditions are met:

1. There is no *network provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services, or has the necessary facilities;
2. There is no *network provider* or *contracting hospital* that provides the required services and meets the adequacy and accessibility requirements of state or federal law.

You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, an *out-of-network provider*.

Such authorized referrals are not available for bariatric surgical services or specified transplants. These services are only covered when performed at a *BDCSC* or by a *UC Family provider*.

Balance billing is when a provider bills you for the difference between the amount they charge and the amount that the *plan* will pay.

Bariatric Coverage Area is the area within the 50-mile radius surrounding a designated bariatric *BDCSC* or *UC Family provider*.

Benefit year is a period that determines the application of your benefits, such as the accumulation toward satisfaction of the annual deductible, accumulation toward annual benefit limitations or maximums, and accumulation toward the annual out-of-pocket liability maximum. *Benefit Year* dates vary by campus – check with the student health services for the dates of your *Benefit Year*.

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a *BDCSC* network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or our relationship with the Blue Cross and Blue Shield Association. *BDCSC* agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *BDCSC* will be the same as for *network providers*. A *network provider* in the Prudent Buyer Plan network is not necessarily a *BDCSC* facility.

Centers of Medical Excellence (CME) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a *CME* network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. *CME* agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *CME* will be the same as for *network providers*. A *network provider* in the Prudent Buyer Plan network is not necessarily a *CME* facility.

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

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross Life and Health Insurance Company shall perform all administrative services in connection with the processing of claims under this *plan* and shall have full and final discretion and authority to determine whether and to what extent members are entitled to benefits under the *plan*.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *members*. A *contracting hospital* is not necessarily a *network provider*. A list of contracting hospitals will be sent on request.

Coverage period is the period during which a student and his or her covered dependents are eligible for coverage and receive the benefits of this *plan*.

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

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

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and self-administering medication 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 use disorders under the supervision of *physicians*.

Dependent is an individual who meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner is an individual who meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS.

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.

Home health agencies are home health care providers who are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and who are 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 California Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to California 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 for the acute phase of a *mental or nervous disorder* or substance use disorder, “hospital” also includes *psychiatric health facilities*.

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.

Insured Student is a person who, by meeting the *plan’s* eligibility requirements for an eligible student, is enrolled under this *plan*. The *insured student* may elect coverage for his or her eligible dependents. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

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

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;
6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient’s illness, injury, or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

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;

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

Member is the *insured student* or *dependent* who is enrolled for benefits under the *plan*.

Mental or nervous disorders, including substance use disorders, 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.

Network 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*
- *Centers for Medical Excellence (CME)*
- *Blue Distinction Centers for Specialty Care (BDCSC)*
- A licensed qualified autism service provider

Network providers agree to accept the *maximum allowed amount* as full payment for covered services. A directory of network providers is available upon request.

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.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank
- A licensed ambulance company
- A *hospice*

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

Out-of-network 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*
- A licensed qualified autism service provider

Remember that the *maximum allowed amount* may only represent a portion of the amount which an *out-of-network provider* charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided; is rendering a service within the scope of that license, and such license is required to render that service; is providing a service for which benefits are specified in this Booklet and when benefits would be provided if the services were provided by a physician as defined above:
 - A 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 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 *psychiatric mental health nurse* (R.N.)*
- A nurse practitioner
- A nurse midwife**
- A physician assistant
- Any agency licensed by the state to provide services for the treatment of *mental or nervous disorders* or substance use disorders, 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 *network 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 this Benefit Booklet and of the Agreement between Anthem Blue Cross Life and Health Insurance Company and the Regents of the University of California. If changes are made to the *plan*, an amendment or revised Benefit Booklet will be issued to each student affected by the change.

Plan administrator refers to the Regents of the University of California, the entity which is responsible for the administration of the *plan*.

Plan year is the start and end date of the *plan* coverage period each year, used for the purposes of the *plan* contract, financial management and data reporting.

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.

Preventive Care Services include routine annual physical examinations, FDA-approved disease screening and testing, 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.

Preventive care services also include additional care, counseling and screening for women including contraceptive care and diabetes screening; well-baby and well-child preventive care; and Tuberculosis screening for students at campus student health services. See more information beginning on page 64, under *Preventive Care Services* in the MEDICAL CARE THAT IS COVERED section.

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.

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

Routine physical examination is a visit to a *physician* or an appropriate clinician in the absence of a specific medical concern, for the purposes of screening for diseases, assessing risk of future medical problems, encouraging a healthy lifestyle through educational intervention, and updating vaccinations. Dependents covered under UC SHIP obtain all medical care, including routine physical exams, immunizations and other preventive services from Anthem *network providers*, outside the student health center. Physical exams for the purposes of employment or for clearance for participation in governmental, academic, recreational or other programs or services are not covered by the *plan*.

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.

Specialist is a *physician* who provides specialized medical treatment, including but not limited to, cardiologist, dermatologist, gastroenterologist, neurologist, obstetrician-gynecologist, oncologist, ophthalmologist, orthopedic surgeon and urologist.

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.

UC Family is the network of UC medical centers, including hospitals and other facilities as well as professional providers that are *network providers*, as defined above. UC Family also includes student health centers on campus though student health clinics are not *network providers*.

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

We (us, our) refers to the *Plan Administrator*.

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

FOR YOUR INFORMATION

After-Hours Nurse Advice

For after-hours nurse advice when student health services is closed, call student health at 1-209-228-2273 and be automatically transferred to the nurse advice service. Voluntary non-registered students and dependents, call 24/7 NurseLine, see information below.

24/7 NurseLine

Your Anthem *plan* also includes 24/7 NurseLine, a 24-hour nurse assessment service to help you make decisions about your medical care 24 hours a day, 365 days a year. This confidential service is available to both covered students and dependents by calling the 24/7 NurseLine toll free at **1-877-351-3457**.

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

- Try home self-care. You may receive a follow-up phone call to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your *physician*.
- Call your *physician* for further discussion and assessment.
- Go to the nearest *emergency* room.
- Call 911 immediately.

In addition to providing a nurse to help you make decisions about your health care, 24/7 NurseLine gives you free unlimited access to its AudioHealth Library featuring recorded information on hundreds of health care topics in English and Spanish. To access the AudioHealth Library, call toll free **1-877-351-3457** and follow the instructions given.

Future Moms

Future Moms is a free program available to pregnant members up to 34 weeks gestation. If you wish to enroll in the Future Moms program, please contact Anthem Blue Cross at **1-866-664-5404**. Information you provide will allow Anthem Blue Cross' specialized nurses to review and assess your potential for having a high risk pregnancy.

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.