

**UNIVERSITY OF CALIFORNIA  
BERKELEY CAMPUS**

*August 15, 2010*

***Student Health Insurance  
Benefit Booklet***

---

Dear Plan Member:

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

*Insured Students* are referred to in this booklet as “you” and “your”. The *plan administrator* is referred to as “we”, “us” and “our”.

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

Please read this Benefit Booklet (“*plan description*”) carefully so that you understand all the benefits your *plan* offers. Keep this Benefit Booklet handy in case you have any questions about your coverage.

**Note:** Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

## COMPLAINT NOTICE

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

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

*Claims Administered by:*

*ANTHEM BLUE CROSS*

*on behalf of*

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

## TABLE OF CONTENTS

<b>INTRODUCTION TO UC BERKELEY STUDENT HEALTH INSURANCE PLAN (SHIP)</b> .....	<b>1</b>
<b>TYPES OF PROVIDERS</b> .....	<b>3</b>
<b>SUMMARY OF BENEFITS</b> .....	<b>5</b>
MEDICAL BENEFITS.....	6
TRANSGENDER SURGERY BENEFITS .....	11
<b>DURING YOUR LIFETIME</b> .....	<b>12</b>
<b>YOUR MEDICAL BENEFITS</b> .....	<b>13</b>
HOW COVERED EXPENSE IS DETERMINED .....	13
DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS .....	14
CONDITIONS OF COVERAGE .....	15
MEDICAL CARE THAT IS COVERED .....	17
MEDICAL CARE THAT IS NOT COVERED.....	30
<b>TRANSGENDER SURGERY BENEFITS</b> .....	<b>36</b>
CONDITIONS FOR COVERAGE.....	36
TRANSGENDER SURGERY CO-PAYMENTS AND MAXIMUMS.....	36
TRANSGENDER SURGERY CARE THAT IS COVERED.....	37
TRANSGENDER SURGERY CARE THAT IS NOT COVERED .....	38
<b>REIMBURSEMENT FOR ACTS OF THIRD PARTIES</b> .....	<b>40</b>
<b>BENEFITS FOR MEDICARE ELIGIBLE STUDENTS</b> .....	<b>41</b>
<b>NON-DUPLICATION OF BENEFIT</b> .....	<b>42</b>
<b>UTILIZATION REVIEW PROGRAM</b> .....	<b>43</b>
THE MEDICAL NECESSITY REVIEW PROCESS.....	48
PERSONAL CASE MANAGEMENT .....	50
DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS.....	52
QUALITY ASSURANCE .....	53
<b>HOW COVERAGE BEGINS AND ENDS</b> .....	<b>54</b>
HOW COVERAGE BEGINS .....	54
HOW COVERAGE ENDS .....	55

**CONTINUATION OF COVERAGE DURING HOSPITALIZATION.....56**  
**CONVERSION .....57**  
**GENERAL PROVISIONS .....58**  
**BINDING ARBITRATION .....64**  
**DEFINITIONS.....65**  
**SCHEDULES FOR NON-PARTICIPATING PROVIDERS.....75**  
**NON-PARTICIPATING PROVIDER EXCEPTIONS .....82**

## INTRODUCTION TO UC BERKELEY STUDENT HEALTH INSURANCE PLAN (SHIP)

WHEN YOU NEED MEDICAL CARE OR MENTAL HEALTH SERVICES, YOU MUST FIRST GO TO THE UNIVERSITY HEALTH SERVICES (UHS) TANG CENTER FOR TREATMENT DURING THEIR REGULAR HOURS OF OPERATION. THE UHS TANG CENTER CAN HELP YOU LOCATE PROVIDERS AND ISSUE REFERRALS TO MEDICAL PROVIDERS WHEN ADDITIONAL CARE OR A SPECIALIST IS NEEDED.

The Tang Center will diagnose and treat most illnesses, coordinate all of your health care and provide a referral to a *participating provider* or *non-participating provider*. See the section entitled TYPE OF PROVIDERS for further information. Referrals are made at the sole and absolute discretion of the Tang Center. **The referral does not guarantee payment or coverage.** The services must be *medically necessary* and a covered benefit under this *plan*. Services which do not require a referral are: *emergency services*, *prescriptions* filled outside UHS; chiropractic services; mammograms; and acupuncture.

**If you receive medical care without a referral, the expenses will not be covered, except for a medical *emergency*.**

### PAYMENT RATES AT THE UHS TANG CENTER

Students will pay \$15 for a primary care office visit and \$30 for an urgent care clinic visit at UHS Tang Center.

Covered *prescriptions* filled at UHS Tang Center will be paid as follows:

- *Generic drug\** ..... **100%** of billed charge after you pay a **\$15** co-payment
- *Brand name drug\** ..... **100%** of billed charge after you pay a **\$25** co-payment

\*Limited to a 30-day supply

- Hormonal contraceptive\*\* ..... **100%** of billed charge after you pay a **\$25** co-payment

\*\*Limited to 3 cycles

Students will pay **20%** of billed charges for all other covered medical services provided by UHS Tang Center.

Covered services at UHS and outside UHS will have a combined maximum as shown under the provision "Medical Benefit Maximums".

## TYPES OF PROVIDERS

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

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

**A directory of participating providers is available upon request.** The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers*. You may call the customer service number listed on your ID card and request for a directory to be sent to you. You may also search for a *participating provider* using the "Provider Finder" function on the website at [www.anthem.com/ca](http://www.anthem.com/ca). The listings include the credentials of *participating providers* such as specialty designations and board certification.

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

**Contracting and Non-Contracting Hospitals.** Another type of provider is the "contracting hospital". This is different from a *hospital* which is a *participating provider*. The *claims administrator* has contracted with most hospitals in California to obtain certain advantages for patients covered under the *plan*. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over **90%**--accept.

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

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

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

## 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 EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") 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.

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

**The coverage under this *plan* is secondary coverage to all other plans for any services not provided by the Student Health Center. See NON-DUPLICATION OF BENEFIT.**

The benefits of this <i>plan</i> are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
--

## MEDICAL BENEFITS

### DEDUCTIBLES

#### Benefit Year Deductible\*

- Student Deductible ..... **\$200**

**\*Exceptions:** In certain circumstances, the Benefit Year Deductible may not apply, as described below:

- The Benefit Year Deductible will not apply to University Health Services and Non-University Health Services pharmacy benefits.
- The Benefit Year Deductible will not apply to outpatient psychotherapy visits for *mental or nervous disorders*, except for those defined as *severe mental disorders*.

### CO-PAYMENTS

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

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

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

#### **\*Exceptions:**

- Your Co-Payment for *covered expense* you incur provided by a *hospital* for inpatient services and supplies will be as follows:
  - a. *Participating provider* and  
*other health care provider hospital* ..... **10%**
  - b. *Non-participating provider hospital*..... **20%**

**Note:** You will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.

- Your Co-Payment for *covered expense* you incur for services provided by a *home health agency*, under the Home Health Care benefit, will be as follows:
  - a. *Participating provider and other health care provider hospital* ..... **No charge**
  - b. *Non-participating provider hospital*.....**20%**

**Note:** You will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.

- Your Co-Payment for *emergency services* or transportation services provided by a ground ambulance company will be **10%** of *covered expense*.
- Your Co-Payment for *emergency services* or transportation services provided by a licensed air ambulance company will be **20%** of *covered expense*.
- Your Co-Payment for physical therapy equipment will be **20%** of billed charges regardless of provider.
- Your Co-Payment for Podiatric services determined to be *medically necessary* will be **20%** of billed charge. See UTILIZATION REVIEW PROGRAM.
- Your Co-Payment for the rental or purchase of durable medical equipment will be **20%** of *covered expense*. You will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.
- Your Co-Payment for covered *drugs* dispensed outside of University Health Services by a *physician* or a licensed pharmacist will be **30%** of billed charge.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed *covered expense*.
  - a. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;
  - b. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist); or
  - c. cancer clinical trials.

- No Co-Payment will be required for the following services regardless of provider. You will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or a *non-participating provider*:
  - a. *Emergency* room services and supplies (for treatment provided within 72 hours of illness or injury);
  - b. Outpatient surgery and supplies provided by a *hospital* including, but not limited to outpatient surgery, radiation therapy, chemotherapy or hemodialysis treatment;
  - c. Outpatient surgery, services and supplies provided by an *ambulatory surgical center*.
  - d. Services and supplies provided under the Acupuncture benefit; and
  - e. Services and supplies provided under the Chiropractic Services benefit.

**Out-of-Pocket Amount\***. After you have made **\$3,000** of out-of-pocket payments for *covered expense* you incur during a *benefit year*, you will no longer be required to pay a Co-Payment for the remainder of that *benefit year*, but you remain responsible for costs in excess of *covered expense*.

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

**Important Note About Covered Expense And Your Co-Payment:** *Covered expense* for *non-participating providers* is significantly lower than what providers customarily charge. (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.) You must pay all of this excess amount in addition to your Co-Payment.

### MEDICAL BENEFIT MAXIMUMS

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

#### Skilled Nursing Facility

- For covered *skilled nursing facility* care.....**100 days**  
per *benefit year*

**Home Health Care**

- For covered home health services ..... **100 visits**  
per *benefit year*

**Prescription Drugs and Medications**

- For all covered *drugs* dispensed by  
a *physician* or a licensed pharmacist..... **\$7,500**  
per *benefit year*

**Hospice Care**

- For all covered *hospice care* ..... **\$5,000**  
during your lifetime

**Mental or Nervous Disorders (not including severe mental disorders)**

- For covered outpatient *physician's* services..... **25 visits\***  
per *benefit year*
- For covered inpatient *physician's* services..... **30 visits\***  
per *benefit year*
- For covered *facility-based care* ..... **30 days\***  
per *benefit year*

\*Not to exceed the *scheduled amount* for *non-participating providers*

**Substance Abuse**

- For covered outpatient *physician's* services..... **30 days\*\***  
per *benefit year\**
- For covered inpatient *physician's* services..... **30 visits\*\***  
per *benefit year*
- For covered *facility-based care* ..... **30 days\*\***  
per *benefit year\**

\* The 30 day limit will not apply to inpatient *hospital* services for detoxification during the acute phase of alcoholism or drug dependence.

\*\*Not to exceed the *scheduled amount* for *non-participating providers*

**Dental Injury**

- For all covered services and supplies ..... **\$300**  
per injury

**Allergy Testing and Injections**

- For all covered services and supplies ..... **\$1,000**  
per *benefit year*

**Physical Therapy, Physical Medicine and Occupational Therapy**

- For all covered services..... **\$1,500**  
per *benefit year*

**Chiropractic Services**

- For all covered services..... **\$25**  
per visit, one visit per day,  
up to **\$100** per *benefit year*

**Podiatric Services**

- For all covered services..... **\$125**  
per *benefit year*

**Acupuncture**

- For all covered services..... **\$25**  
per visit, one visit per day,  
up to **\$100** per *benefit year*

**Repatriation of Remains**

- For all covered services..... **\$7,500**

**Medical Evacuation**

- For all covered services..... **\$10,000**

**LIFETIME MAXIMUM**

- Medical benefits for  
care of the *student's* newborn child ..... **\$25,000**  
during the newborn child's  
first 30 days after birth
- For all medical benefits ..... **\$400,000**  
during your lifetime

## TRANSGENDER SURGERY BENEFITS

### CO-PAYMENTS

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

#### Hospital Services

- Inpatient services and supplies .....10%
- Operating room and special treatment room .....10%
- Intensive care .....10%
- Nursing care .....10%
- Blood, blood plasma, derivatives and factors .....10%
- Inpatient drugs, medications and oxygen .....10%
- Outpatient services (except emergency room).....20%

#### Skilled Nursing Facility Services

- Skilled nursing care .....20%

#### Physician

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

**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:

**Transgender 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 expenses such as meals ..... **\$25**  
per day,  
for up to 21 days per trip

**Skilled Nursing Facility**

- For covered *skilled nursing facility* care..... **100 days**

**Transgender Lifetime Maximum ..... \$75,000**  
**during your lifetime**

## YOUR MEDICAL BENEFITS

### HOW COVERED EXPENSE IS DETERMINED

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

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

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

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

**Exception.** For *covered expense* incurred for antigens, the maximum *covered expense* is based on billed charge.

**Non-Participating Providers.** The maximum *covered expense* for services provided by a *non-participating provider* will always be the lesser of the billed charge or the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS, and the definition of "Scheduled Amount" in the DEFINITIONS section. You will be responsible for any billed charge which exceeds the *scheduled amount* for services provided by a *non-participating provider*.

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

**Other Health Care Providers.** The maximum *covered expense* for services provided by an *other health care provider* will always be the lesser of the billed charge or the *reasonable charge*. You will be responsible for any billed charge which exceed the *reasonable charge* for the services of an *other health care provider*.

**Exceptions:**

1. For *covered expense* incurred for antigens, the maximum *covered expense* is based on billed charge.
2. If Medicare is the primary payor, *covered expense* does not include any charge:
  - a. By a *hospital*, in excess of the approved amount as determined by Medicare; or
  - b. By a *physician* or *other health care provider*, in excess of the lesser of the maximum *covered expense* stated above, or:
    - i. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
    - ii. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

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

**DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS**

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

**DEDUCTIBLES**

Charges that are considered *covered expense* will apply toward satisfaction of any deductible except as specifically indicated in this booklet.

**Benefit Year Deductibles.** Each year, you will be responsible for satisfying the Benefit Year Deductible before benefits are paid.

### **CO-PAYMENTS**

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

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

### **OUT-OF-POCKET AMOUNTS**

If, after you have met your Benefit Year Deductible, you pay Co-Payments equal to your Out-of-Pocket Amount per *student* during a *benefit year*, you will no longer be required to make Co-Payments for any *covered expense* you incur during the remainder of that year. Charges which are not considered *covered expense* will not be applied toward satisfaction of an Out-of-Pocket Amount.

### **MEDICAL BENEFIT MAXIMUMS**

The *plan* does not make benefit payments for any *student* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits paid to you on your behalf under any other health plan provided by the *plan administrator*, or any of its affiliates, which is sponsored by the *plan administrator*.

### **CONDITIONS OF COVERAGE**

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

#### **NON-EMERGENCY CARE**

1. You must go to the University Health Services (UHS) Tang Center first for medical or mental health services or supplies.
2. The UHS must authorize the services or supplies as *medically necessary* in order for you to receive care outside the Tang Center.
3. 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.
4. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy.

5. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
6. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
7. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
8. 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.
9. All services and supplies must be ordered by a *physician*.

#### **EMERGENCY CARE**

1. Prior authorization by UHS is not required for *emergency services*.
2. The *claims administrator* will determine whether the services rendered were for *emergency care* as defined, prior to any claim payment. Emergency room services determined not to be for *emergency services* will be subject to the Co-Payment as described under the section SUMMARY OF BENEFIT - CO-PAYMENTS.

## 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, the *plan* 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. The *plan* will pay for up to a maximum of **\$25** for all covered services rendered during each visit, further limited to one visit per day and up to a total of **\$100** per *benefit year*.

**Ambulance.** The following ambulance services:

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

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

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

**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. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

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

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

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

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.

3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

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

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

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

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

### **Chemotherapy**

**Chiropractic Services.** Chiropractic service for manual manipulation of the spine to correct subluxation demonstrated by *physician*-read x-ray. The *plan's* maximum payment is limited to **\$25** for each visit, one visit per day, and up to a maximum total of **\$100** during a *benefit year* for all covered services.

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

- Injectable drugs and implants for birth control, administered in a *physician's* office.

- Intrauterine contraceptive devices (IUDs), cervical caps, and diaphragms, dispensed by a *physician*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices, cervical caps, or diaphragms.

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

#### **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*. This applies only if (a) the *student* is developmentally disabled, or (b) the *students* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) treating an *accidental injury* to natural teeth which occurs while you are covered under this *plan*. Services must be received during the six months following the date of injury. Damage to natural teeth due to chewing or biting is not *accidental injury*. Covered services for treatment of an *accidental injury* to natural teeth will not exceed **\$300** per injury.

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

1. The following equipment and supplies:
  - a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

- b. Insulin pumps.
- c. Pen delivery systems for insulin administration (non-disposable).
- d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.
- e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

2. Diabetes education program which:

- a. Is designed to teach a *student* about the disease process and the daily management of diabetic therapy;
- b. Includes self-management training, education, and medical nutrition therapy to enable the *student* 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, glucagon, and other *prescription drugs* for the treatment of diabetes.
- b. Insulin syringes, disposable pen delivery systems for insulin administration.
- c. Testing strips, lancets, and alcohol swabs.

**Diagnostic Services.** Outpatient diagnostic imaging and laboratory services.

**Durable Medical Equipment.** Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Rental or purchase of other medical equipment and supplies which are:

- 1. Of no further use when medical needs end;
- 2. For the exclusive use of the patient;
- 3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

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

### **Hemodialysis Treatment**

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

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

In no event will benefits exceed 100 visits during a *benefit year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are 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.

**Hospice Care.** The *plan* will pay up to a maximum of **\$5,000** during your lifetime 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. Oxygen and related respiratory therapy supplies.
9. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

You must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified by your *physician* and submitted to the *claims administrator*.

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**

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

**Immunizations.** The *plan* will pay for the following immunizations: (a) diphtheria/tetanus/pertussis, administered alone or together; (b) measles, mumps, and rubella; (c) Varicella; (d) influenza; (e) hepatitis A and hepatitis B; (f) pneumococcal; (g) polio; (h) meningococcal; and (i) human papillomavirus vaccine.

**Injectable Drugs.** *Drugs* that are inhaled, intravenous, intramuscular and administered under the skin (except for insulin) administered in a *physician's* office, outpatient setting or through home health care. For information on which drugs require prior authorization, call 1-800-700-2541.

**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.** The *plan* will pay benefits towards reimbursement of *medically necessary* expenses incurred transporting you back to your country of legal residence for medical care and treatment.

The *plan* will pay medical evacuation benefits if the following conditions are met:

1. You are in the United States on a non-immigrant visa;
2. Your illness commenced, or injury occurred, while you were in the United States;
3. Your illness commenced, or injury occurred, while you were covered under this *plan*;
4. Your *physician*, in the United States, certifies in writing that you are:  
(a) medically stable; and (b) you require further medical care and treatment for your accident and illness; and
5. You have incurred expense for your transportation back to your country of legal residence for your medical care and treatment.

The *claims administrator* will determine whether the expenses satisfy the conditions above. The *plan* will pay up to a maximum of **\$10,000** for transportation back to your country of legal residence for medical care and treatment. No payment will be made under this *plan* for expenses incurred for: (a) mild conditions which can be treated in the United States and do not prevent you from participating in your studies; (b) services received before your *effective date* or after your coverage ends; (c) services when your *physician* does not certify, in writing, that you need further medical care or treatment for an illness or injury that commenced or occurred, respectively, in the United States; and (d) the cost of transportation for a family member or traveling companion accompanying you.

**Mental or Nervous Disorders.** Covered services shown below for the treatment of *mental or nervous disorders*, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*, limited to **30** days per *benefit year*.

Note: Pre-service review will not be required for inpatient *hospital* services and services from a *residential treatment center*. You will still be required to get a referral from UHS Tang Center.

2. *Physician* visits during a covered inpatient *stay* for the treatment of *mental or nervous disorders*. All inpatient *physician* visits are limited to a combined total of **30** visits per *benefit year*.
3. *Physician* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders*. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders*. A combined total of **25** visits per *benefit year* will apply for outpatient *physician* visits.

Covered services for the treatment of *severe mental disorders* will not be subject to any limitations applicable to *mental or nervous disorders* shown in the SUMMARY OF BENEFITS or under these "Mental or Nervous Disorders" provision. Such services will be subject to all other terms, conditions, limitations and exclusions, including applicable Medical Benefit Maximums. Please refer to the DEFINITIONS section for a description of "severe mental disorders".

**(Note:** Covered expense for *non-participating providers* will not exceed the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.)

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

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

**Physical Therapy, Physical Medicine and Occupational Therapy.** The following services, up to a maximum payment of **\$1,500** during a *benefit year*, provided by a *physician* under a treatment plan:

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

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

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

### **Pregnancy and Maternity Care**

Benefits listed below are provided for a female *insured student*.

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical benefits for care of a newborn child, if the child's natural mother is a *student*, up to a maximum of **\$25,000** in the first 30 days after birth. A separate deductible and out-of-pocket amount will apply to the newborn child. See the SUMMARY OF BENEFITS for the deductible and out-of-pocket amounts.

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

**Prescription Drugs and Medications.** *Drugs* and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*. The *drugs* or medicine must be dispensed by a *physician* or a licensed pharmacist. Also included are *drugs* prescribed for *mental or nervous disorders* or substance abuse, hormonal contraceptives prescribed by a *physician*, and formulas prescribed by a *physician* for the treatment of phenylketonuria. The *plan* will pay up to **\$7,500** per *benefit year* for covered *prescription drugs* and medications.

### **Professional Services**

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

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

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

### **Radiation Therapy**

**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.

**Repatriation of Remains.** The *plan* will pay benefits towards reimbursement if *medically necessary* expenses are incurred by the person or persons preparing and transporting your remains to your country of legal residence, subject to the following:

1. You are in the United States on a non-immigrant visa;
2. Your death occurred while you were in the United States;
3. Your death occurred while you were covered under this *plan*; and
4. One or more persons have incurred expense for the preparation and transportation of your remains to your country of legal residence for burial.

The *claims administrator* will determine whether the expenses satisfy the conditions above. The *plan* will pay up to a maximum of **\$7,500** for *medically necessary* expenses incurred by the person or persons preparing and transporting your remains to your country of legal residence. No payment will be made under this *plan* for expenses incurred for: (a) services received before your *effective date* or after your coverage ends, (b) services furnished to prepare and transport your remains to your country of legal residence if your death occurred outside the United States; and (c) the cost of transportation for a family member or traveling companion accompanying your remains.

**Skilled Nursing Facility.** Inpatient services and supplies provided by a *skilled nursing facility*, for up to 100 days per *benefit year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. For the purpose of care provided for the treatment of *severe mental disorders* or substance abuse, the term “skilled nursing facility” includes *residential treatment center*.

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

**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 as *prescription drugs* (see “Prescription Drugs and Medications”). Special food products that are not available from a *pharmacy* are covered as medical supplies under your *plan’s* medical benefits.

**Substance Abuse.** Covered services shown below for the treatment of substance abuse, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*, limited to thirty days per *benefit year*. This 30-day limit will not apply to inpatient *hospital* services for detoxification during the acute phase of alcoholism or drug dependence.

Note: Pre-service review will not be required for inpatient *hospital* services and services from a *residential treatment center*. This will not apply to inpatient *hospital* services for detoxification during the acute phase of alcoholism or drug dependence. You will still be required to get a referral from UHS Tang Center.

2. *Physician* visits during a covered inpatient *stay*. All *physician* visits are limited to a combined total of 30 visits per *benefit year*.
3. *Physician* visits for outpatient treatment of substance abuse. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy). All *physician* visits are limited to a maximum of 30 days per *benefit year*.
4. Counseling provided at University Health Services Tang Center.

**(Note:** Covered expense for *non-participating providers* will not exceed the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.)

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

## **MEDICAL CARE THAT IS NOT COVERED**

(Exclusions and Limitations)

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

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

**Acts of Nature.** Conditions that result from acts of nature, when government funds are available for treatment of illness or injury arising from such events.

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

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

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

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

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

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

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

**Education or Counseling.** Educational services, or nutritional counseling, except as specifically provided or arranged by the *claims administrator*, or as stated under the "Diabetes" provision of MEDICAL CARE THAT IS COVERED.

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

**Exercise Equipment.** Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

**Experimental or Investigative.** Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review.

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

**Food or Dietary Supplements.** Food or dietary supplements, except as specifically stated under the "Special Food Products" provision of MEDICAL CARE THAT IS COVERED.

**Government Treatment.** Any services actually given to you by a local, state or federal government agency, 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.

**Hearing Aids or Tests.** Hearing aids. Routine hearing tests.

**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*.

**Mental or Nervous Disorders.** Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental or Nervous Disorders" or "Substance Abuse" provisions of MEDICAL CARE THAT IS COVERED.

**Nasal Surgery.** Nasal surgery except *medically necessary* surgical treatment for acute sinusitis, or due to a medically documented *accidental injury* that occurred while you are eligible under this *plan*.

**Not Covered.** Services received before your *effective date* or after your coverage ends, except as specifically stated under CONTINUATION OF COVERAGE DURING HOSPITALIZATION.

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

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

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

**Organ and Tissue Transplants.** Expenses incurred in connection with an organ or tissue transplant.

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

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

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

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

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

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

**Prescription Drugs and Medications.** Any drug or medicine requiring or dispensed with a written *prescription* of a *physician*, except as specifically stated in the "Prescription Drugs and Medications" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the *student* 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 employment or government authority, except as specifically stated in the "Cervical Cancer Screening", "Breast Cancer", or "Prostate Cancer Screening" provisions of MEDICAL CARE THAT IS COVERED.

**Services not approved by University Health Services.** Services not approved by University Health Services, unless the services are for emergency care, routine and diagnostic mammogram examinations to detect breast cancer, acupuncture, chiropractic and *prescription drugs*.

**Services of Relatives.** Professional services received from a person who lives in your home or who is related to you by blood or marriage.

**Services received after the Student's coverage ends,** except as specifically stated in the section entitled CONTINUATION OF COVERAGE DURING HOSPITALIZATION.

**Sterilization Reversal.** Reversal of sterilization.

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

**Treatment for injuries sustained under the following circumstances:**

1. While participating in any intercollegiate sport, contest or competition, or
2. While traveling to or from such sport, contest or competition as a participant, or
3. While participating in any practice or conditioning program for such sport, contest or competition, or
4. Due to any University-sponsored (including intramural) program in the martial arts.

**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.

**Weight Alteration Programs (Inpatient and Outpatient).** Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by the *claims administrator's* Medical Policy.

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

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

## TRANSGENDER SURGERY BENEFITS

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

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

### CONDITIONS FOR COVERAGE

1. The *student* is at least 18 years old;
2. The *student* has criteria for the diagnosis of “true” transsexualism\*
3. The *student* has completed a program with a mental health professional trained in the treatment of gender dysphoria as defined by the Harry Benjamin International Association Guidelines; and
4. The services are authorized (See UTILIZATION REVIEW PROGRAM for details).

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

### TRANSGENDER SURGERY CO-PAYMENTS AND MAXIMUMS

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

## CO-PAYMENTS

Your Co-Payment will be subtracted from the amount of *covered expense* remaining.

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

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

## TRANSGENDER SURGERY BENEFIT MAXIMUM

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

## TRANSGENDER SURGERY CARE THAT IS COVERED

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

**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.

**Diagnostic Services.** Outpatient diagnostic imaging and laboratory services.

### Hospital

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

## Professional Services

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

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

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

**Transgender Surgery Travel Expense.** The following travel expenses in connection with an authorized, transgender surgery performed at a facility which is designated by the *claims administrator* and approved for the transgender 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 transgender surgery requested, not to exceed **\$250** per person per trip.
- b. Hotel accommodations, not to exceed **\$100** per day for up to 21 days per trip, limited to one room, double occupancy.
- c. Other expenses, such as meals, not to exceed **\$25** per day for each person, for up to 21 days per trip.

## TRANSGENDER SURGERY CARE THAT IS NOT COVERED

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

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

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

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

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

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

- Transgender surgery services and related covered services will be provided as follows:
  - a. The Surgical Procedure:
    - i. You meet the Conditions for Coverage listed for the Transgender Surgery Benefits;
    - ii. The services are *medically necessary* and appropriate; and
    - iii. The *physicians* on the surgical team and the facility in which the surgery is to take place are approved for the transgender surgery requested.
  - b. Transgender Surgery Travel Expense:
    - i. It is for transgender surgery and related services, authorized by us; and
    - ii. The transgender surgery must be performed at a specific facility designated by us which is approved for the transgender surgery requested.

## REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.
  - If we paid the provider other than on a capitated basis, our lien will not be more than the amount we paid for those services.
  - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
  - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
  - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
  - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
  - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

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

### **BENEFITS FOR MEDICARE ELIGIBLE STUDENTS**

*Insured students* eligible for Medicare receive the full benefits of this *plan*, except for those *students* listed below:

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

In cases where exceptions 1 or 2 apply, payment will be determined under the *plan* and the amount of benefits available from Medicare will be subtracted from such payment. The *plan* will pay the amount that remains after subtracting Medicare's payment. Please note, the *plan* will not pay any benefit when Medicare's payment is equal to or more than the amount which the *plan* would have paid in the absence of Medicare.

**For example:** Say exception 1 or 2 applies to you, and you are billed for **\$100** of *covered expense*. And say in the absence of Medicare, the *plan* would have paid **\$80**. If Medicare pays **\$50**, the *plan* would subtract that amount from the **\$80** and pay **\$30**. However, if in this same example, Medicare's payment is **\$80** or more, the *plan* will not pay a benefit. Any combined benefit from Medicare and this *plan* will equal, but not exceed, what the *plan* would have paid if you were not eligible for Medicare.

## NON-DUPLICATION OF BENEFIT

Benefits are not provided under this *plan* to the extent that care or treatment is obtained from, provided by, or payment for which is made by any of the following:

1. Any other contract (except automobile medical insurance), agreement, plan or disability insurance which provides, pays for or reimburses expense incurred for hospitalization, surgical, medical or dental care or treatment.
2. University Health Services on an outpatient basis or any other University outpatient medical facility, except for those services for which there is a charge to the student.
3. Any local, state (except Medi-Cal) or federal governmental agency, including charges for services or benefits for which the *student* is entitled to receive reimbursement under Medicare.
4. Any other plan sponsored by the Regents.

This means that payment will be made only toward the unpaid balance after payment has been made by any other hospital, surgical, medical or dental insurance you have.

The *claims administrator* will reduce the amount payable under the *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. The amount from other plans includes any amount to which you are entitled, whether or not a claim is made for the benefits. This *plan* is secondary coverage to all other plans or policies.

## 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.

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 it has been 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 "Effect on Benefits" portion of UTILIZATION REVIEW PROGRAM.

### UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays*.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Podiatric services.
- Transgender surgery.

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

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

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures and admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
  - Scheduled, non-emergency inpatient *hospital stays* (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
  - Home health care.
  - Admissions to a *skilled nursing facility*.
  - Podiatric services.
  - Transgender surgery.
2. **Concurrent 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*.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

## EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:

- Scheduled, non-emergency inpatient *hospital stays* (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
- Home health care services if:
  - a. The services can be safely provided in your home, as certified by your attending physician;
  - b. Your attending *physician* manages and directs your medical care at home; and
  - c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the home health agency.
- Services provided in a *skilled nursing facility* if:
  - a. You require daily skilled nursing or rehabilitation, as certified by your attending physician.
  - b. You were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and
  - c. You will be treated for the same condition for which you were treated in the hospital.
- Podiatric services if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
- Transgender surgery and related covered services will be provided as follows:
  - a. The Surgical Procedure:
    - i. You meet the Conditions for Coverage listed for the Transgender surgery Benefit;
    - ii. The services are *medically necessary* and appropriate; and
    - iii. The *physicians* on the surgical team and the facility in which the surgery is to take place are approved for the transgender surgery requested.

- b. Transgender surgery Travel Expense:
  - i. It is for transgender surgery and related services, authorized by the *claims administrator*;
  - ii. The transgender surgery must be performed at a specific facility designated by the *claims administrator* which is approved for the transgender surgery requested.

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

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

## HOW TO OBTAIN UTILIZATION REVIEWS

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

**Pre-service Reviews.** 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 *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* directly. The toll-free number for pre-service review is printed on your identification card.
- 3. If you do not receive the certified 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 stays*, the *claims administrator* will, if appropriate, specify the type and level of services, as well as their duration. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

### **Concurrent Reviews**

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure, unless extraordinary circumstances\* prevent such notification within that time period.
2. When participating providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.
3. When 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 are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

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

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

## THE MEDICAL NECESSITY REVIEW PROCESS

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

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.

4. If the *claims administrator* does not have the information they need, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
  - an explanation of the reason for the decision,

- reference of the criteria used in the decision to modify or not certify the request,
  - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
  - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

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

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

## **PERSONAL CASE MANAGEMENT**

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

## HOW PERSONAL CASE MANAGEMENT WORKS

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

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

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

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

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

## EFFECT ON BENEFITS

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

3. An authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *student*.
4. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *student*.

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

#### **DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS**

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

## **QUALITY ASSURANCE**

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

## HOW COVERAGE BEGINS AND ENDS

### HOW COVERAGE BEGINS

#### ELIGIBLE STATUS

1. **Insured Students.** The following class of students are automatically enrolled as *insured students*:

Class 1: All registered undergraduate and graduate students of the Berkeley Campus of the University of California, including registered international students.

Class 2: All non-registered "Filing Fee" or "Withdrawal" status students of the Berkeley Campus who are completing work under the auspices of the University of California but are not attending classes. Students on Filing Fee or Withdrawal status may purchase SHIP coverage for a maximum of two semesters. All non-registered UC Berkeley "Concurrent Enrollment" students who are completing degree requirements by taking courses through UCB Extension. Concurrent Enrollment students can purchase the *plan* through the Student Health Insurance Office for a maximum of one semester only. (They are not automatically enrolled.)

**Note:** A *student* may waive coverage online at [www.uhs.berkeley.edu/students/insurance/waiverselect.shtml](http://www.uhs.berkeley.edu/students/insurance/waiverselect.shtml) during the waiver period, April 1 through July 15. The waiver is effective for one academic year and must be completed again during the waiver period each Fall Semester. For *students* enrolling during the Spring Semester, the waiver period is December 1 through January 2. Another waiver must be completed in the fall of the next academic year.

#### ELIGIBILITY DATE

Periods of Coverage: Fall - August 15 to January 14; Spring - January 15 to August 14. However, for late enrollees approved by the University, coverage begins on the date of enrollment, subject to the payment of full premium.

#### ENROLLMENT

We do not require written applications from covered persons. The Regents will maintain records of all students registered in each academic semester and will enroll all students, other than those who provide proof that they have other health coverage that meets minimum requirements, for coverage under this *plan* in each academic semester for which they are registered.

**Important Note for Newborn Children.** If the *insured student* is already covered, any child born to the *insured student* will be covered from the moment of birth. Coverage will be in effect for 30 days.

### HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the *plan* terminates, your coverage ends at the same time. This *plan* may be canceled or changed without notice to you.
2. If the *plan* no longer provides coverage for the class of *students* to which you belong, your coverage ends on the effective date of that change.
3. If the *student* graduates or withdraws from the University, the *student's* coverage continues through the last day of the *coverage period* during which the *student* graduates or withdraws from the University.
4. 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. The *student* is disruptive, unruly or abusive to the extent that the ability of the UHS to provide services to the *student* and other clients is seriously impaired, or the *student* fails to maintain a satisfactory provider-patient relationship after University Health Services and the *plan administrator* have made all reasonable efforts to promote such a relationship.
  - b. The *student* knowingly gives University Health Services or the *plan administrator* incorrect or incomplete information in any document or fails to notify the *plan administrator* of changes in his or her status that may affect eligibility for benefits.
  - c. The *student* knowingly misrepresents plan enrollment status or coverage.
  - d. The *student* knowingly presents an invalid *prescription*.
  - e. The *student* knowingly misuses or allows the misuse of the plan identification card.
  - f. The *student* fails to pay any premium amount due within the time specified in writing. A *student* terminated for nonpayment may be re-enrolled in the *plan* upon full payment of all amounts due.

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 University Health Services Executive Director is responsible for the final decision on termination of enrollment in the Student Health Insurance Plan.

5. If a registered UC Berkeley *student* has been terminated from the *plan* and has no comparable major medical health insurance coverage, as required by the University of California Regents, University Health Services will provide the *student* with a list of addresses and phone numbers of comparable health insurance plans to which the *student* may apply for coverage. The *student* is wholly responsible for the cost of any plan in which they enroll and any medical care not covered under that plan, including costs of applying for coverage and plan premiums.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE DURING HOSPITALIZATION and CONVERSION.

### **CONTINUATION OF COVERAGE DURING HOSPITALIZATION**

If a *student* is confined in a *hospital* when coverage ends and is under the treatment of a *physician*, the benefits of this *plan* continue to be provided for services treating only the illness or injury for which the *student* is hospitalized. No benefits are provided for services treating any other illness, injury or condition.

Benefits are provided under this section only until the first of the following occurs:

1. It is no longer *medically necessary* for inpatient care to be provided, or
2. The *student* is discharged from the *hospital*, or
3. The maximum benefits of this *plan* are paid.

## CONVERSION

To apply for a conversion plan, you must submit an application to the *claims administrator* within 63 days of the date your coverage under the *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

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

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

## GENERAL PROVISIONS

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

**Independent Contractors.** The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor is 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 *participating providers*.

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

When you obtain health care services through BlueCard outside of California, the amount you pay for covered services is calculated on the lower of:

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

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes, it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or

with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered a final price.

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

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

### **Terms of Coverage**

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

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

**Free Choice of Provider.** This *plan* in no way interferes with your right as a *student* 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*.

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this *plan*.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. 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, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* are negotiated on a case-by-case basis. The *non-participating provider* will be asked to agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the *non-participating provider* does not agree to accept said reimbursement and contractual requirements, the *non-participating 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 *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with the *claims administrator* terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

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

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer

to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

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

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

other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

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

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

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

**Notice of Claim.** You or the provider of service must send properly and fully completed claim forms to the *claims administrator* within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 9 months will be allowed. We are not liable for the benefits of the *plan* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

**Payment to Providers.** The benefits of this *plan* will be paid directly to *contracting hospitals, participating providers,* and medical transportation providers. Also, *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the *plan's* obligation to you for those covered services.

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

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

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

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

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

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

## **BINDING ARBITRATION**

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

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

The *student* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

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

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

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

## DEFINITIONS

The meanings of key terms used in this *benefit booklet* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your *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 referral** occurs when you, because of your medical needs, are referred to a *non-participating provider*, but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*; and
3. The referral has been authorized by the *claims administrator* before services are rendered.

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

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

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

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

**Contracting hospital** is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *students*. A list of contracting hospitals will be sent on request.

**Coverage period** is the two periods during the year for which benefits are provided. The two periods are January 15th through August 14th, and August 15th through January 14th.

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

**Creditable coverage** is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site

medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the pre-existing condition exclusion period, if any, under this *plan*.

You will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

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

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

**Drug (prescription drug)** means a drug approved by the Food and Drug Administration for general use by the public which requires a prescription before it can be obtained. For the purposes of this *plan*, insulin will be considered a prescription drug.

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

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

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

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

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

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

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

**Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care for the acute phase of a *mental or nervous disorder, severe mental disorder, or substance abuse*, "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 (student)** is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself.

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

**Medically necessary** procedures, supplies, equipment or services are those considered to be:

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

**Mental or nervous disorders**, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (*e.g.*, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be; but medical conditions that are caused by your behavior that may be associated with these mental conditions (*e.g.*, self-inflicted injuries) and treatment for *severe mental disorders* are not subject to *plan* limitations that apply to mental or nervous disorders.

**Negotiated rate** is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements.

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

**Non-participating 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:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*; or
8. A clinical laboratory.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

**Other health care provider** is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

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

**Participating provider** is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;

7. A skilled nursing facility, or
8. A clinical laboratory.

*Participating providers* agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

**Pharmacy** means a licensed retail pharmacy.

**Physician** means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:
  - a. A dentist (D.D.S. or D.M.D.)
  - b. An optometrist (O.D.)
  - c. A dispensing optician
  - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
  - e. A licensed clinical psychologist
  - f. A chiropractor (D.C.)
  - g. An acupuncturist (A.C.)
  - h. A clinical social worker (L.C.S.W.)
  - i. A marriage and family therapist (M.F.T.)
  - j. A physical therapist (P.T. or R.P.T.)\*
  - k. A speech pathologist\*
  - l. An audiologist\*
  - m. An occupational therapist (O.T.R.)\*
  - n. A respiratory care practitioner (R.C.P.)\*
  - o. A *psychiatric mental health nurse* (R.N.)\*
  - p. A nurse midwife\*\*
  - q. A registered dietitian (R.D.)\* for the provision of diabetic medical nutrition therapy only

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

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

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

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

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

**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 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.

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

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

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

**Scheduled amount** is determined according to the SCHEDULES FOR NON-PARTICIPATING PROVIDERS. Any amount by which a *non-participating provider's* charge exceeds this schedule will not be considered *covered expense*. **You are responsible for paying any such excess amount.**

**Service area** is the area in which the provider's principal place of business is located. The counties encompassed by each service area are listed in the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.

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

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

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

Benefits for severe mental disorders will be provided according to the *plan's* benefits for medical conditions, and will not be subject to *plan* provisions for *mental or nervous disorders*.

**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. For the purpose of care provided for the treatment of *mental or nervous disorders, severe mental disorders, or substance abuse*, the term “skilled nursing facility” includes *residential treatment center*.

**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 is not a general practitioner, internist, family practitioner, nurse practitioner, pediatrician, gynecologist, or obstetrician.

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

**Exception.** With respect to an inpatient stay due to mental disorders, and subject to medical review by the *claims administrator*, a day pass is not considered a discharge from the facility.

**Unit Value Schedule** lists the unit values of medical services. For any procedure not listed in the schedule, the *claims administrator* will provide a benefit on the basis of comparable service. Benefits are determined based on the schedule in effect at the time the claim is paid. The unit value schedule listed in this *benefit booklet* is only a partial listing.

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

**We (us, our)** refers to University of California, Berkeley Campus.

**Year or benefit year** is a 12 month period starting August 15 at 12:01 a.m. Pacific Standard Time.

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

## SCHEDULES FOR NON-PARTICIPATING PROVIDERS

This section explains how the *claims administrator* determines the *scheduled amount* (the maximum amount the *claims administrator* will consider *covered expense for non-participating providers*) and is subject to the maximums, conditions, exclusions and limitations of this *plan*.

### SERVICE AREAS

A provider's *service area* is determined by the area in which the provider's principal place of business is located.

- **Service Area 1:** Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.
- **Service Area 2:** Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.
- **Service Area 3:** Counties of Marin, San Francisco, San Mateo and Santa Clara.
- **Service Area 4:** Counties of Los Angeles and Riverside (City of Palm Springs only).
- **Service Area 5:** Orange County.
- **Service Area 6:** Counties of Kern, Riverside (except City of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.
- **Service Area 7:** San Diego County.
- **Service Area 8:** Counties of Fresno, San Joaquin, Sonoma and Stanislaus.
- **Service Area 9:** Imperial County.
- **Service Area 10:** Outside California.

**Important Note:** The *claims administrator* has the right to adjust, without notice, all schedules found in this section in order to maintain the relationship between these *scheduled amounts* for *non-participating providers* and the fee schedule negotiated by the *claims administrator* with *participating providers*. Benefits are determined based on the schedule in effect at the time services are rendered.

### **CHARGES BY A PHYSICIAN WHO IS A NON-PARTICIPATING PROVIDER**

1. Charges for services of a *physician* who is a *non-participating provider* are determined by multiplying the "Unit Value" of the service (listed in the Unit Value Schedule) by the appropriate "Unit Allowance" listed in the Unit Allowance Schedule. The "Unit Allowance" varies according to the *service area* of the provider.
2. For any procedure not listed in the Unit Value Schedule, the *claims administrator* provides a benefit on the basis of comparable service.
3. The Unit Value Schedule listed in this *benefit booklet* is only a partial listing.

For services provided by a *physician* who is a *non-participating provider*, *covered expense* will not exceed the amount determined by the following process. First, the *claims administrator* will determine the appropriate "Unit Allowance" for the service by determining in which *service area* the *physician* performed the service. Then, the *claims administrator* will multiply the "Unit Value" of that service by the appropriate "Unit Allowance". The resulting amount is the maximum amount of *covered expense* the *claims administrator* will pay for that service under the *plan*.

The *claims administrator* has developed a Unit Value Schedule for covered services. An excerpt of this Schedule is set forth in this section. Notice that for each service listed in the Schedule, there is a "Procedure Code" and a "Unit Value". *Physicians* use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Medical Association and are widely used throughout the medical profession.

Your *physician* should be able to identify for you which "Procedure Code(s)" applies to the service(s) to be performed. Remember, the maximum allowable *covered expense* may be less than the *physician's* charge for such services. You are responsible for paying any amount by which this charge exceeds the maximum allowable *covered expense*, in addition to any Deductible and Co-Payment required under this *plan*.

If you want assistance in determining the maximum allowable *covered expense* for services provided by a *physician* who is a *non-participating provider*, you may telephone the *claims administrator* at the number shown on your identification card.

Remember, if you obtain your health care services from a *participating provider*, you will be able to determine the amount of your financial responsibility more simply. *Participating providers* have agreed not to charge any more for their services than the *negotiated rate*, leaving you only the amount of your Deductible and Co-Payment described in the SUMMARY OF BENEFITS.

#### UNIT ALLOWANCE SCHEDULE

Service Area	Surgery	Anesthesia	Medicine	Radiology	Pathology
1	\$110.00	\$25.00	\$4.80	\$9.50	\$1.05
2	110.00	25.00	4.80	9.50	1.05
3	120.00	26.00	5.10	10.50	1.15
4	120.00	26.00	5.10	10.50	1.15
5	120.00	26.00	5.10	10.50	1.15
6	110.00	25.00	4.80	9.50	1.05
7	110.00	25.00	4.80	9.50	1.05
8	110.00	25.00	4.80	9.50	1.05
9	110.00	25.00	4.80	9.50	1.05
10	120.00	26.00	5.10	10.50	1.15

#### UNIT VALUE SCHEDULE (Partial Listing)

PROC CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
<b>Skin</b>		
10060	Incision and drainage of abscess .....	0.58
11100	Biopsy of skin, including closure .....	0.43
11770	Excision of pilonidal cyst or sinus .....	1.59
<b>Breast</b>		
19120	Excision of breast tumor, unilateral.....	2.80
19200	Radical mastectomy, including pectoral muscles and axillary nodes.....	7.25

**Fractures**

21315	Nasal, simple, closed reduction .....	1.16
25565	Closed radial and ulnar shafts, manipulative reduction .....	3.71
27232	Femur and neck, manipulative reduction, including traction .....	5.63

**Heart**

33400	Aortic valvuloplasty, with bypass .....	14.79
33420	Valvotomy, mitral valve, closed .....	11.04

**Throat**

42650	Dilation, salivary duct .....	0.42
42820	Tonsillectomy and adenoidectomy, under 12 years .....	2.64

**Digestive**

43620	Total gastrectomy .....	10.25
44950	Appendectomy .....	3.96
47600	Cholecystectomy .....	5.67

**Rectum**

46200	Fissurectomy .....	2.01
46250	Hemorrhoidectomy, external, complete .....	2.48

**Male**

55801	Prostatectomy, perineal (sub-total) .....	8.16
-------	---	------

**Female**

58180	Supracervical (sub-total) hysterectomy with or without tubes or ovaries .....	7.15
-------	--	------

**Maternity**

59510	Cesarean section, including antepartum and postpartum care .....	11.98
-------	---	-------

**Thyroid**

60200	Local excision of cyst of thyroid .....	4.54
60240	Thyroidectomy, total or complete .....	7.89

**Ear**

69420	Myringotomy .....	0.75
69501	Transmastoid antrotomy .....	5.17

**SURGERY (two or more surgical procedures).** When two or more surgical procedures are performed during the same operative session, the following Unit Values apply unless otherwise stated in this Schedule:

- Major procedure ..... **100%** of the Unit Value
- Second procedure ..... **50%** of the Unit Value
- Third procedure ..... **25%** of the Unit Value
- Fourth procedure ..... **25%** of the Unit Value
- Fifth procedure ..... **25%** of the Unit Value

**SURGERY (assistant surgeon).** The Unit Value for the services of an assistant surgeon is **20%** of the unit value for the primary surgeon.

**ANESTHESIA (anesthesiologist or anesthetist).** The total Unit Value for the services of an anesthesiologist or anesthetist is the basic anesthesia value for that procedure and a Unit Value for the actual time spent administering anesthesia.

<b>PROC CODE</b>	<b>BASIC ANESTHESIA</b>	<b>UNIT VALUE</b>
01400	Knee joint .....	3.0
01462	Lower leg, ankle, or foot .....	3.0
00566	Direct coronary artery bypass grafting without pump oxygenator.....	12.0
00740	Upper gastrointestinal endoscopic.....	4.0
00940	Vaginal .....	3.0
01961	Cesarean delivery .....	5.6

<b>MEDICINE</b>	<b>UNIT VALUE</b>	
99205	Office Visit -- initial comprehensive exam..... 19.44	
99212	Office Visit -- problem-focused examination evaluation, and/or treatment .....	4.61
99231	Hospital Visit -- problem-focused examination, evaluation, and/or treatment, same illness .....	5.27
99241	Consultation -- problem-focused examination and/or evaluation .....	10.59

<b>RADIOLOGY</b>	<b>UNIT VALUE</b>	
<b>Diagnostic</b>		
70210	Sinuses and paranasal, limited..... 2.75	
70250	Skull, limited..... 3.03	
74241	Upper gastrointestinal tract..... 7.71	
74415	Nephrotomography .....	8.95

**Therapeutic**

77261 Therapeutic radiology treatment planning,  
simple..... 6.55

**Nuclear Medicine**

78000 Thyroid uptake ..... 4.00  
79000 Hyperthyroidism, initial evaluation ..... 15.88

**PATHOLOGY** **UNIT VALUE**

81000 Urinalysis, routine, complete..... 4.32  
87081 Microbiology - culture, bacterial screening ..... 10.58

**CHARGES BY A HOSPITAL WHICH IS A NON-PARTICIPATING PROVIDER**

1. The maximum charge the *claims administrator* considers covered expense for outpatient care provided by a *hospital* which is a *non-participating provider* is a *reasonable charge*.
2. The maximum charge the *claims administrator* considers covered expense for inpatient care provided by a *hospital* which is a *non-participating provider* is shown in the schedule below. The amount varies by the *service area* of the *hospital* (amounts shown are for each day).

**INPATIENT HOSPITAL SCHEDULE**

<b>Service Area</b>	<b>Non-Contracting Psychiatric Health Facility Services</b>	<b>Mental or Nervous Disorders and Substance Abuse</b>	<b>All Other Conditions</b>
1	\$150	\$175	\$540
2	150	175	540
3	162	175	540
4	162	175	580
5	162	175	540
6	150	175	540
7	150	175	540
8	150	175	540
9	150	175	540
10	162	175	580

**CHARGES BY AN AMBULATORY SURGICAL CENTER WHICH IS A NON-PARTICIPATING PROVIDER**

The maximum charge the *claims administrator* considers *covered expense* for outpatient surgery provided by an *ambulatory surgical center* which is a *non-participating provider* is shown in the schedule below. The amount varies by the *service area* of the center.

**AMBULATORY SURGICAL CENTER SCHEDULE**

<b>Service Area</b>	<b>Each Session</b>
1.....	<b>\$540</b>
2.....	<b>540</b>
3.....	<b>540</b>
4.....	<b>580</b>
5.....	<b>540</b>
6.....	<b>540</b>
7.....	<b>540</b>
8.....	<b>540</b>
9.....	<b>540</b>
10.....	<b>580</b>

**CHARGES BY OTHER SPECIFIC PROVIDERS WHICH ARE NON-PARTICIPATING PROVIDERS**

The maximum charge the *claims administrator* considers *covered expense* for services and supplies provided by the following providers which are *non-participating providers* is the lesser of the billed charge or the *reasonable charge*:

1. A *home health agency* or *visiting nurse association*;
2. A facility which provides diagnostic imaging services;
3. A clinical laboratory;
4. A *skilled nursing facility*; or
5. A durable medical equipment outlet.

## NON-PARTICIPATING PROVIDER EXCEPTIONS

Subject to all other provisions of the *plan*, your Co-Payment for the services of a *non-participating provider* is the same as for a *participating provider* for the following:

- *Emergency services* provided by other than a *hospital*;
- The first 48 hours of *emergency services* provided by a *hospital* (this exception will continue beyond the first 48 hours if, in the *claims administrator's* judgment, you cannot be safely moved);
- An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;
- Charges of a *physician* who has a specialty which is not represented in the Prudent Buyer Plan network; or
- Cancer Clinical Trials.

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

**Determination of Covered Expense.** In addition, the *claims administrator* pays a greater amount of *covered expense* under these circumstances. For these exceptions, *covered expense* for the services of a *non-participating provider* is the lesser of the billed charge or the amount shown below.

Type of Provider	Maximum Covered Expense is ..
------------------	-------------------------------

Physicians.....	the Customary and Reasonable Charge*
-----------------	--------------------------------------

All Other Non-Participating Providers .....	a Reasonable Charge*
---	----------------------

### \*Exception

Maximum Covered Expense for Cancer Clinical Trials is the amount that ordinarily applies when services are provided by a *participating provider*.