

**UNIVERSITY OF CALIFORNIA
STUDENT HEALTH INSURANCE PLAN**

August 1, 2011

UC Berkeley

***Prudent Buyer Plan
Benefit Booklet***

Dear Plan Member:

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

Students and covered dependents (“members”) are referred to in this booklet as “you” and “your”. The *plan administrator* is referred to as “we”, “us” and “our”.

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

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

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).

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

UC SHIP website: www.ucop.edu/ucship

COMPLAINT NOTICE

All complaints and disputes relating to benefits provided by this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number 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 regarding benefits will be acknowledged in writing, together with a description of how the claims administrator proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Grievances relating to eligibility for coverage under the *plan* should be directed to your campus University Health Services, in writing, within 60 days of the notification that you are not eligible for coverage. You should include all information and documentation on which your grievance is based. University Health Services will notify you in writing of its conclusion regarding your eligibility. If University Health Services confirms the determination that you are ineligible, you may request, in writing, that the systemwide Student Health Insurance Plan (UC SHIP) Administrative Office review this decision. Your request for review should be sent within 60 days after receipt of the notice from University Health Services confirming your ineligibility and should include all information and documentation relevant to your grievance. Your request for review should be directed to: UC SHIP Administrative Office, UC Office of the President, 300 Lakeside Drive, Oakland, CA 94612. The decision of the UC SHIP Administrative Office will be final.

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

UC SHIP website: www.ucop.edu/ucship

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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INTRODUCTION TO THE STUDENT HEALTH INSURANCE PLAN

IF YOU ARE ENROLLED UNDER THIS PLAN AS A STUDENT AND YOU NEED MEDICAL CARE YOU MUST FIRST GO TO UNIVERSITY HEALTH SERVICES (UHS) FOR TREATMENT DURING THEIR REGULAR HOURS OF OPERATION. UNIVERSITY HEALTH SERVICES WILL HELP YOU LOCATE PROVIDERS AND ISSUE REFERRALS TO MEDICAL PROVIDERS WHEN ADDITIONAL CARE OR A SPECIALIST IS NEEDED.

University Health Services (UHS) will diagnose and treat most illnesses, coordinate all of your health care and provide a referral to a *participating provider* or *non-participating provider*. Referrals are made at the sole and absolute discretion of UHS. **The referral does not guarantee payment or coverage.** The services must be *medically necessary* and a covered benefit under this *plan*.

IF YOU RECEIVE MEDICAL CARE WITHOUT PRIOR REFERRAL FROM UHS, THE EXPENSES WILL NOT BE COVERED, EXCEPT FOR URGENT OR EMERGENCY CARE OF A MEDICAL OR PSYCHIATRIC EMERGENCY.

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

NOTE: Dependents may choose any health care professional or facility that is classified a *participating provider* or as an *other health care provider* which provides care covered under this *plan*. To avoid denial of benefits, make sure your *dependent* uses only providers who participate in the *claims administrator's* preferred provider organization program called the Prudent Buyer Plan or who are classified as *other health care providers*. See the section entitled TYPES OF PROVIDERS for further information.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

Insured Students

1. All registered students of the University of California Berkeley campus.
2. All students of the University of California Berkeley campus who are registered-in-absentia.

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

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

contacting Wells Fargo Insurance Services at 800-853-5899.

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

Insured Dependents

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

- iv. *Child of the insured student's domestic partner:* A *child* of the *insured student's domestic partner* under the age of 26 is a dependent as of the effective date of the domestic partnership.
- v. Foster Child: A foster *child* under the age of 18 is a dependent from the moment of placement with the *insured student* as certified by the agency making the placement.
- vi. Dependent Adult Child: An unmarried child who is 26 years of age or more and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. The University may request proof of these conditions in order to continue coverage. The University must receive the certification, at no expense to the University, within 60 days of the date the *student* receives the request. The University may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

- 2. Students are required to provide proof of dependent status when enrolling their dependents in the *plan*. The following documents will be accepted:
 - a. For *spouse*, a marriage certificate

- b. For a *domestic partner*, a Declaration of Domestic Partnership issued by the State of California, or of same-sex legal union other than marriage formed in another jurisdiction, or a completed Declaration of Domestic Partnership form issued by the University
- c. For natural *child*, a birth certificate showing the student is the parent of the *child*
- d. For stepchild, a birth certificate, and a marriage certificate showing that one of the parents listed on the birth certificate is married to the student
- e. For a natural *child* of a *domestic partner*, a birth certificate showing the domestic partner is the parent of the *child*
- f. For adopted or foster *child*, documentation from the placement agency showing that the student or the *domestic partner* has the legal right to control the *child's* health care.

PERIODS OF COVERAGE

| | Eligibility Date | Termination Date |
|--------|-------------------------|-------------------------|
| Fall | 8/15/2011 | 1/14/2012 |
| Spring | 1/15/2012 | 8/14/2012 |

ENROLLMENT

We do not require written applications from registered students. The University of California will maintain records of all students registered in each academic semester and will enroll all registered 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.

Students who lose their other health coverage during the coverage period must notify University Health Services with an official written letter of termination from the previous health insurance carrier. Students will be enrolled in the *plan* as of the date of their loss of other coverage if they notify University Health Services within 31 days of the loss of their coverage. If the student does not notify University Health Services within

the 31 days, coverage will be effective on the date the student pays the full premium. The premium is not pro-rated for enrollment occurring after the start of a coverage period.

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

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

1. For *spouse*, the date of issuance of the marriage certificate.
2. For a *domestic partner*, the date of the Declaration of Domestic Partnership issued by the State of California, other jurisdiction, or the date the completed Declaration of Domestic Partnership form issued by the University is received by University Health Services.
3. For natural *child*, the date of birth.
4. For adopted or foster *child*, the date of placement with the student or *domestic partner*.
5. For any dependent, the date of loss of other coverage. An official letter of termination from the insurance carrier must be provided at the time of enrollment in SHIP.

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

Important Note for Newborn Children. If the student is already covered, any *child* born to the student will be covered under the parent's benefits from the moment of birth, provided that the *plan* is notified of the birth within 31 days. Coverage will be in effect for 31 days or until the newborn reaches \$25,000 in claim expenses, whichever occurs first. For continued newborn coverage beyond the 31 days and/or \$25,000 (see MEDICAL BENEFIT MAXIMUMS), the newborn must be enrolled as a dependent within 31 days of the date of birth.

The student must contact Wells Fargo Insurance Services to notify the *plan* of the child's birth for limited coverage or to enroll the child as a *dependent*. Their Customer Care telephone number is 1-800-853-5899.

HOW COVERAGE ENDS

For students, coverage ends as provided below:

1. If the *plan* terminates, the student's coverage ends at the same time. This *plan* may be canceled or changed at any time without notice. If the *plan* terminates or changes, an *insured student* will remain covered for claims incurred but not filed or paid prior to *plan* termination or change.
2. If the *plan* no longer provides coverage for the class of students to which an *insured student* belongs, the student's coverage ends on the effective date of that change.
3. If the student graduates from the University, the student's coverage continues through the last day of the coverage period during which the student graduates from the University.
4. If the student withdraws or is dismissed from the University, whether or not coverage will be continued after the date of the withdrawal or dismissal will be determined by campus policy. Contact University Health Services for more information.
5. Enrollment in the *plan* may be terminated for the reasons listed below. The student shall be notified in writing of the termination. Termination shall be effective no less than 30 days following the date of the written notice.
 - a. The student is disruptive, unruly or abusive to the extent that the ability of University Health Services 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 Director of UC SHIP is responsible for the final decision on termination of enrollment in the *plan*.

- 6. If a registered student has been terminated from the *plan* and has no comparable major medical health insurance coverage, as required by the Regents of the University of California, 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 he or she enrolls and any medical care not covered under that plan, including costs of applying for coverage and plan premiums.

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

Important: If a marriage or domestic partnership terminates, or if a covered *child* loses dependent child status, the student must give or send Wells Fargo Insurance Services written notice of the termination and loss of eligibility status. Coverage for a former *spouse* or *domestic partner*, or dependent *child*, if any, ends according to the "Eligible Status" provisions. If the *plan* suffers a loss because the student fails to notify Wells Fargo Insurance Services of the termination of their marriage or domestic partnership, or of the loss of a *child's* dependent status, we may seek recovery from the student for any actual loss resulting thereby. Failure to provide written notice to Wells Fargo Insurance Services will not delay or prevent termination of coverage for the *spouse*, *domestic partner* or *child*. If the student notifies Wells Fargo Insurance Services in writing to cancel coverage for a former *spouse*, *domestic partner* or *child*, if any, immediately upon termination of the student's marriage, domestic partnership or the *child's* loss of dependent child status, such notice will be considered compliance with the requirements of this provision.

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

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION WHICH DESCRIBES WHAT TYPES OR GROUPS OF PROVIDERS MAY FURNISH HEALTH CARE SERVICES OR SUPPLIES UNDER THE PLAN. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

IMPORTANT NOTE: For *dependents*, services provided by *non-participating providers* are covered under the *plan* only with an *authorized referral* from a *participating provider*, for *emergency services* or for *urgent care*.

Participating Providers. The *plan* has made available to the *members* a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called the Prudent Buyer Plan. They have agreed to provide our *members* with health care at a negotiated rate. The cost of benefits provided under this *plan* will generally be lower for *participating providers* than for *non-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 that a directory be sent to you. You may also search for a *participating provider* using the "Provider Finder" function on the website at www.ucop.edu/ucship. The listings include the credentials of the *claims administrator's 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. **For those which do not (called *non-contracting hospitals*), there is a significant benefit penalty in your *plan*.**

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

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

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

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the *prescription drug maximum allowed amount* to fill the *prescription*. You pay only your Co-Insurance or Co-Payment amount.

"Non-Participating Pharmacies" have not agreed to the *prescription drug maximum allowed amount*. The amount that will be covered as a *prescription drug covered expense* may be significantly lower than amount customarily charged by these providers.

All prescription drug services for dependents must be provided by Participating Pharmacies in order to be covered under the *plan*.

Centers of Medical Excellence. The *claims administrator* is providing access to the following separate *Centers of Medical Excellence (CME)* networks. The facilities included in each of these *CME* networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, *CME* agree to accept the *negotiated rate* as payment in full for covered services. **These procedures are covered only when performed at a *CME*.**
- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a *CME*.**

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

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.

For your convenience, this summary provides a brief outline of your benefits. You should review the entire Benefit Booklet for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*, subject to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *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 except Medi-Cal, MRMIP and TriCare, for any services not provided by University Health Services. See EXCESS COVERAGE.

The benefits of this *plan* may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS FOR STUDENTS

DEDUCTIBLES

Benefit Year Deductible. All medical services and supplies covered under this *plan* are subject to the Benefit Year Deductible below when received outside of University Health Services:

- Per Individual Student\$200

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

- The Benefit Year Deductible will not apply to the “Medical Evacuation” and “Repatriation of Remains” benefits.
- The Benefit Year Deductible will not apply to Prescription Drug benefits.
- The Benefit Year Deductible will not apply to services provided by a *participating provider* that have a set-dollar Co-Payment, including office visits to *physicians, emergency* or urgent care, physical therapy, physical medicine, occupational therapy, speech therapy, chiropractic services, acupuncture, and osteopathic manipulation. However, the Benefit Year Deductible will apply to other charges made during an office visit, such as for testing procedures, surgery, etc.
- The Benefit Year Deductible will not apply to the following immunizations provided by a *participating provider*:
 - a. Diphtheria/Tetanus/Pertussis
 - b. Measles, Mumps and Rubella
 - c. Varicella
 - d. Influenza
 - e. Hepatitis A and Hepatitis B
 - f. Pneumococcal
 - g. Meningococcal
 - h. Polio
 - i. Human Papillomavirus

All other immunizations are subject to the Benefit Year Deductible.

- The Benefit Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *CME*.

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- The Benefit Year Deductible will not apply to Transgender Surgery travel expenses authorized by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.
- The Benefit Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant procedure provided at a designated *CME*.
- The Benefit Year Deductible will not apply to *emergency* or *urgent care* claims.
- The Benefit Year Deductible will not apply to diabetes education.

Deductible for Non-PPO Hospital or Residential Treatment Center.

All inpatient medical services and supplies are subject to the Non-Participating Facility Inpatient Deductible below when received at a *non-participating hospital* or *residential treatment center*.

Non-Participating Facility Inpatient Deductible \$500

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

- The Non-Participating Facility Inpatient Deductible will not apply to *emergency* admissions.
- The Non-Participating Facility Inpatient Deductible will not apply to services for which the Anthem Blue Cross has negotiated a single case payment agreement with the non-participating facility.

NOTE: The Non-Participating Facility Inpatient Deductible is separate from the Benefit Year Deductible. Satisfaction of the Benefit Year Deductible does not contribute toward meeting the Non-Participating Facility Inpatient Deductible.

CO-INSURANCE, CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

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

- *Participating Providers*.....**10%**
- *Other Health Care Providers*.....**10%**
- *Non-Participating Providers*.....**40%**

Exceptions:

- Your Co-Insurance 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. *Emergency services* provided by other than a *hospital*;
 - b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Co-Insurance will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in the *claims administrator's* judgment, cannot be safely moved);
 - c. An *authorized referral* from a *physician* who is a *participating provider* or UHS to a *non-participating provider*;
 - d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist); or
 - e. Cancer Clinical Trials;
 - f. The services of an anesthesiologist and assistant surgeon who are *non-participating providers* when the *hospital* where the surgery is to be performed, or *ambulatory surgical center*, AND the operating *physician* are BOTH *participating providers*.
- Your Co-Payment will be **\$100** for *emergency room services*. This Co-Payment will not apply if you are admitted as a *hospital inpatient* immediately following emergency room treatment.
- Your Co-Payment will be **\$50** for *urgent care services* provided by a *participating provider*.
- You are not required to make a Co-Payment or Co-Insurance payment for the following services provided by a *participating provider*:
 - a. Services provided under the Physical Exam benefit.
 - b. Services under the Adult Preventive Services benefit.
 - c. Home health care.
 - d. The following immunizations:
 - Diphtheria/Tetanus/Pertussis
 - Measles, Mumps and Rubella
 - Varicella

- Influenza
- Hepatitis A and Hepatitis B
- Pneumococcal
- Meningococcal
- Polio
- Human Papillomavirus

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

- You will not be required to pay Co-Insurance for *medically necessary* air ambulance transportation. *Medically necessary* ground ambulance transportation has a **10%** Co-Insurance
- Your Co-Payment for your first office visit for pregnancy care to a *physician* who is a *participating provider* will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount. **Note:** This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.
- Your Co-Payment for each home visit by, or an office visit to, a *physician* who is a *participating provider* and who is not a *specialist* (for other than pregnancy care), will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount. **Note:** This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.
- Your Co-Payment for each home visit by, or an office visit to, a *specialist* who is a *participating provider* will be **\$20**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount. **Note:** This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.
- Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.
- Your Co-Insurance for bariatric surgical procedures determined to be *medically necessary* and performed at a designated *CME* will be the same as for *participating providers*. **Services for bariatric surgical procedures are not covered when**

performed at other than a designated CME. See UTILIZATION REVIEW PROGRAM.

NOTE: Co-Payments or Co-Insurance payments do not apply for bariatric travel expenses authorized by the *claims administrator*. Bariatric travel expense is available when the closest CME is in excess of 50 miles from the *member's* residence.

- Your Co-Insurance for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated CME will be the same as for *participating providers*. **Services for specified transplants are not covered when performed at other than a designated CME.** See UTILIZATION REVIEW PROGRAM.

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

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

NOTE: Co-Payments or Co-Insurance payments do not apply for 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.)

- You are not required to make a Co-Payment or Co-Insurance payment for services under the Medical Evacuation and Repatriation of Remains benefits.
- Medical benefits while traveling out of the country are covered as follows:
 - a. Services provided by a *participating provider* will be reimbursed at **90%** of the *negotiated rate*. You will be responsible for the remaining **10%** of the *negotiated rate*.

- b. Services provided by a *non-participating provider* will be reimbursed at **60%** of the covered billed charges. You will be responsible for **40%** of the remaining covered billed charges.
- c. Services provided by an *other health care provider*, will be reimbursed at **90%** of the covered billed charges. You will be responsible for **10%** of the remaining covered billed charges.

For Your Information

- **“Co-Payment”** is the defined dollar amount of *covered expense* which you are responsible to pay.
- **“Co-Insurance”** is the percentage of *covered expense* which you are responsible to pay.
- **“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.
- In addition to the Co-Payment or Co-Insurance shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.

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

- *Participating providers* and *other health care providers*.....**\$3,000/Per Individual Student**
- *Non-participating providers***\$6,000/Per Individual Student**

Note: The out-of-pocket amount for *participating providers* and *other health care providers* is separate from the *non-participating providers* out-of-pocket amount. Neither accumulates toward satisfying the other.

***Exceptions:**

- Any Co-Payments you make for services of a *participating provider* will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay Co-Payments even after you have reached that amount.

- Expense which (1) is applied toward any deductible, (2) is incurred for non-covered services or supplies, or (3) is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

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

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

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

Home Health Care

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

Hospice Care

- For bereavement counseling **\$25**
per visit; up to four visits during
the 12 months following your death
- For all covered *hospice* care
(including bereavement counseling) **\$5,000**
per *benefit year*

Home Infusion Therapy

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

*Maximum applies to *non-participating providers* only

Ambulance

- For all covered air ambulance services..... **\$25,000**
per *benefit year*

Medical Benefits for Care of the Member’s Newborn Child

- For all covered services..... **\$25,000**
during the newborn child’s first 31 days after
birth provided the *plan* has been notified and if
the child has not been enrolled as a *dependent*

Durable Medical Equipment

- For covered charges for rental or purchase **\$5,000**
per *benefit year*

Hearing Aids

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

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

- For all covered outpatient services..... **\$5,000**
(combined) per *benefit year*

**Acupuncture, Chiropractic Care &
Osteopathic Manipulation**

- For all covered services..... **20 visits**
(combined) per *benefit year*

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode
(limited to 6 trips per episode)
 - For transportation to the *CME*..... **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room,
double occupancy

- For expenses such as meals**\$25**
per day for each person,
for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
 - For transportation to the *CME*.....**\$250**
for round trip coach airfare
 - For hotel accommodations.....**\$100**
per day, for up to 7 days
 - For other reasonable expenses
(excluding tobacco, alcohol, drug
and meal expenses).....up to **\$25**
per day, for up to 7 days per trip

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
 - For transportation to the *CME*.....up to **\$130**
per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
 - For transportation to the *CME*.....up to **\$130**
per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
 - Hotel accommodationsup to **\$100**
per day, for up to 2 days per trip,
limited to one room, double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)
 - Hotel accommodationsup to **\$100**
per day, for up to 4 days,
limited to one room, double occupancy
 - For other reasonable expenses
(excluding tobacco, alcohol, drug
and meal expenses).....up to **\$25**
per day, for up to 4 days per trip

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

Transgender Lifetime Maximum

For all covered services, including Transgender Surgery Travel Expense benefits**\$75,000**
during your lifetime

Medical Evacuation

- For all covered services.....**\$10,000**
maximum payment per trip

Repatriation of Remains

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

Overall Lifetime Maximum

- For all medical benefits.....**\$400,000**
during your lifetime

MEDICAL BENEFITS FOR DEPENDENTS

NOTE: Dependents may choose any health care professional or facility that is classified a *participating provider* or as an *other health care provider* which provides care covered under this *plan*. To avoid denial of benefits, make sure your *dependent* uses only providers who participate in the *claims administrator's* preferred provider organization program called the Prudent Buyer Plan or who are classified as *other health care providers*. See the section entitled TYPES OF PROVIDERS for further information.

DEDUCTIBLE

Benefit Year Deductible. All medical services and supplies covered under this *plan* are subject to the Benefit Year Deductible below when received outside of University Health Services:

- Per Individual Dependent **\$400**

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

- The Benefit Year Deductible will not apply to the “Medical Evacuation” and “Repatriation of Remains” benefits.
- The Benefit Year Deductible will not apply to Prescription Drug benefits.
- The Benefit Year Deductible will not apply to: (a) *physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; (b) Physical Exam benefit services; and (c) Adult Preventive Services.
- The Benefit Year Deductible will not apply to the following immunizations:
 - a. Diphtheria/Tetanus/Pertussis
 - b. Measles, Mumps and Rubella
 - c. Varicella
 - d. Influenza
 - e. Hepatitis A and Hepatitis B
 - f. Pneumococcal
 - g. Meningococcal
 - h. Polio
 - i. Human Papillomavirus

All other immunizations are subject to the Benefit Year Deductible.

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- The Benefit Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *CME*.
- The Benefit Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant procedure provided at a designated *CME*.

CO-INSURANCE, CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

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

- *Participating Providers*.....**20%**
- *Other Health Care Providers***20%**
- *Non-Participating Providers (Only permitted for an emergency or with an authorized referral)***20%**

Exceptions:

- In addition to the **20%** Co-Insurance above, you are required to make a **\$100** Co-Payment each time you receive *emergency* room services. This **\$100** Co-Payment will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.
- In addition to the **20%** Co-Insurance above, you are required to make a **\$50** Co-Payment each time you receive *urgent care* services.
- You are not required to make a Co-Payment or Co-Insurance payment for the following services:
 - Physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit.
 - Services provided under the Physical Exam benefit.
 - Services under the Adult Preventive Services benefit.
- You are not required to make a Co-Payment or Co-Insurance payment for the following immunizations:
 - Diphtheria/Tetanus/Pertussis
 - Measles, Mumps and Rubella
 - Varicella
 - Influenza
 - Hepatitis A and Hepatitis B

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- f. Pneumococcal
- g. Meningococcal
- h. Polio
- i. Human Papillomavirus

All other immunizations are subject to a **20%** Co-Insurance.

- Your Co-Insurance for your first office visit for pregnancy care to a *physician* who is a *participating provider* will be **20%** of *covered expense*. After that first visit, you are not required to make a Co-Insurance payment but you remain responsible for expenses in excess of the *covered expense* incurred.

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

- Your Co-Insurance for bariatric surgical procedures determined to be *medically necessary* and performed at a designated *CME* will be **20%**. **Services for bariatric surgical procedures are not covered when performed at other than a designated *CME*.** See UTILIZATION REVIEW PROGRAM.

Note: Co-Payments or Co-Insurance payments do not apply for bariatric travel expenses authorized by the *claims administrator*. Bariatric travel expense is available when the closest *CME* is in excess of 50 miles from the *member's* residence.

- Your Co-Insurance for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated *CME* will be **20%**. **Services for specified transplants are not covered when performed at other than a designated *CME*.** See UTILIZATION REVIEW PROGRAM.

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

- You are not required to make a Co-Payment or Co-Insurance payment for services under the Medical Evacuation and Repatriation of Remains benefits.

DEPENDENTS

- Medical benefits while traveling out of the country are covered as follows:
 - a. Services provided by a *participating provider* will be reimbursed at **80%** of the *negotiated rate*. You will be responsible for the remaining **20%** of the *negotiated rate*.
 - b. Services provided by a *non-participating provider* (*emergencies* only) will be reimbursed at **80%** of the covered billed charges. You will be responsible for **20%** of the remaining covered billed charges.
 - c. Services provided by an *other health care provider*, will be reimbursed at **80%** of the covered billed charges. You will be responsible for **20%** of the remaining covered billed charges.

For Your Information:

- **“Co-Payment”** is the set dollar amount of *covered expense* which you are responsible to pay.
- **“Co-Insurance”** is the percentage of *covered expense* which you are responsible to pay.
- **“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.
- 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*. Remember, *non-participating providers* are covered only by referral from a *participating provider* or for emergency treatment services.

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

- Per Individual Dependent **\$6,000**

Exceptions:

- Any Co-Payments you make for *emergency* room care services will not be applied toward the satisfaction of your Out-of-Pocket Amount.

In addition, you will be required to continue to pay a Co-Payment for *emergency* room care services even after you have reached that amount.

- Any Co-Payments you make for *urgent care* services will not be applied toward the satisfaction of your Out-Of-Pocket Amount. In addition, you are required to continue to pay a Co-Payment for urgent care services even after you have reached that amount.
- Expense which is applied toward any deductible, 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.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

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

Home Health Care

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

Hospice Care

- For bereavement counseling **\$25**
per visit; up to four visits during
the 12 months following your death
- For all covered *hospice care*
(including bereavement counseling) **\$5,000**
per *benefit year*

Ambulance

- For all covered air ambulance services **\$25,000**
per *benefit year*

Medical Benefits for Care of the Member’s Newborn Child

- For all covered services **\$25,000**
during the newborn child’s first 31 days after
birth provided the *plan* has been notified and if
the child has not been enrolled as a *dependent*

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Durable Medical Equipment

- For covered charges for rental or purchase **\$5,000**
per *benefit year*

Hearing Aids

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

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

- For all covered outpatient services..... **\$5,000**
(combined) per *benefit year*

**Acupuncture, Chiropractic Care &
Osteopathic Manipulation**

- For all covered services..... **20 visits**
(combined) per *benefit year*

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode
(limited to 6 trips per episode)
 - For transportation to the *CME*..... **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room,
double occupancy
 - For expenses such as meals **\$25**
per day for each person,
for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per
episode)
 - For transportation to the *CME*..... **\$250**
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 7 days

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- For other reasonable expenses (excluding tobacco, alcohol, drug and meal expenses)..... up to **\$25**
per day, for up to 7 days per trip

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
 - For transportation to the *CME*..... up to **\$130**
per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
 - For transportation to the *CME*..... up to **\$130**
per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
 - Hotel accommodations up to **\$100**
per day, for up to 2 days per trip,
limited to one room, double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)
 - Hotel accommodations up to **\$100**
per day, for up to 4 days,
limited to one room, double occupancy
 - For other reasonable expenses (excluding tobacco, alcohol, drug and meal expenses)..... up to **\$25**
per day, for up to 4 days per trip

Medical Evacuation

- For all covered services..... **\$10,000**
maximum payment per trip

Repatriation of Remains

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

Lifetime Maximum

- For all medical benefits..... **\$400,000**
during your lifetime

D E P E N D E N T S

PRESCRIPTION DRUG BENEFITS FOR STUDENTS

PRESCRIPTION DRUG CO-PAYMENTS. The following Co-Payments apply for each prescription:

Retail Pharmacies: The following Co-Payments or Co-Insurance amounts apply for a 30-day supply of medication.

University Health Services Pharmacies

- *Generic drugs*\$5
- *Brand name drugs*\$25

Participating Pharmacies

- *Generic drugs*\$5
- *Formulary brand name drugs*\$25
- *Non-formulary brand name drugs*\$40
- *Compound medications*\$40

The formulary may be viewed on the *plan* website, located at www.ucop.edu/ucship. The formulary does not apply to prescription medications obtained at a UHS pharmacy.

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

Non-Participation Pharmacies

- *Generic drugs*\$5
 plus **40%** of the remaining *prescription drug covered expense* & costs in excess of the *prescription drug maximum amount allowed*

- *Formulary brand name drugs* **\$25**
 plus **40%** of the remaining *prescription drug covered expense* & costs in excess of the *prescription drug maximum amount allowed*

- *Non-formulary brand name drugs* **\$40**
 plus **40%** of the remaining *prescription drug covered expense* & costs in excess of the *prescription drug maximum amount allowed*

The formulary may be viewed on the *plan* website, located at www.ucop.edu/ucship. The formulary does not apply to prescription medications obtained at a UHS pharmacy.

PRESCRIPTION DRUG BENEFIT MAXIMUM. We will pay up to the following amount of *prescription drug covered expense*:

- Benefit Year Maximum **\$10,000**

Important Note about *Prescription Drug Covered Expense* and Your Co-Payment.

- The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. Your co-payment amount for *non-formulary drugs* is higher than for *formulary drugs*. Any *participating pharmacy* can assist you in purchasing a *formulary drug*.

- *Prescription drug covered expense* for *non-participating pharmacies* is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a *non-participating pharmacy*.

- If your *pharmacy's* retail price for a *drug* is less than the co-payment shown above, you will not be required to pay more than that retail price.

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

PRESCRIPTION DRUG BENEFITS FOR DEPENDENTS

PRESCRIPTION DRUG CO-PAYMENTS AND CO-INSURANCE. The following Co-Payments and Co-Insurance amounts apply for each prescription:

Retail Pharmacies: The following Co-Payments or Co-Insurance amounts apply for a 30-day supply of medication. Note: Unless an exception is made, after the first two month supply of a *specialty drug* is obtained through a retail *pharmacy*, the drug is available only through the Specialty Drug Program. See Specialty Drug Prescriptions below.

Participating Pharmacies

- *Generic drugs*\$5
- *Formulary brand name drugs*30%
of the *prescription drug covered expense*
- *Non-formulary brand name drugs*30%
of the *prescription drug covered expense*
- *Compound medications*.....30%
of the *prescription drug covered expense*

The formulary may be viewed on the *plan* website, located at www.ucop.edu/ucship.

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

NOTE. *Prescriptions* filled at *non-participating pharmacies* are not covered under this *plan*.

Mail Order Prescriptions: The following Co-Payments or Co-Insurance amounts apply for a 90-day supply of medication. **Note:** *Specialty drugs* are not available through the mail service program, see Specialty Drug Prescriptions below.

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- *Generic drugs* **\$10**
- *Formulary brand name drugs* **30%**
of the *prescription drug covered expense*
- *Non-formulary brand name drugs* **30%**
of the *prescription drug covered expense*

The formulary may be viewed on the *plan* website, located at www.ucop.edu/ucship.

Specialty Drug Prescriptions: The following Co-Payments or Co-Insurance amounts apply for a 30-day supply of medication obtained from the Specialty Drug Program.

- *Generic drugs* **\$5**
- *Formulary brand name drugs* **30%**
of the *prescription drug covered expense*
- *Non-formulary brand name drugs* **30%**
of the *prescription drug covered expense*

The formulary may be viewed on the *plan* website, located at www.ucop.edu/ucship.

PRESCRIPTION DRUG BENEFIT MAXIMUM. We will pay up to the following amount of *prescription drug covered expense*:

- Benefit Year Maximum **\$5,000**

Important Note about *Prescription Drug Covered Expense* and Your Co-Payment.

- The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. Your co-payment amount for *non-formulary drugs* is higher than for *formulary drugs*. Any *participating pharmacy* can assist you in purchasing a *formulary drug*.
- If your *pharmacy's* retail price for a *drug* is less than the co-payment shown above, you will not be required to pay more than that retail price.

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

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YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

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

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

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

Non-Participating Providers (for *dependents*, permitted only with an *authorized referral by a participating provider* or for an *emergency*) and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* will always be the lesser of the billed charge or (1) for a *physician*, the *customary and reasonable charge* or (2) for other than a *physician*, the *reasonable charge*. You will be responsible for any billed charge which exceeds the *customary and reasonable charge* or the *reasonable charge*.

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

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital*, in excess of the approved amount as determined by Medicare; or

2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* stated above, or the approved amount as determined by Medicare; or
4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the maximum *covered expense* stated above, or the limiting charge as determined by Medicare.

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

WITH RESPECT TO STUDENT MEDICAL BENEFITS

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

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

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

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. 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 (see pages 13 & 23) before we begin to pay benefits.

Exceptions:

- The Benefit Year Deductible will not apply to services provided at University Health Services on the participating University of California campuses.
- The Benefit Year Deductible will not apply to Prescription Drug benefits.
- With respect to students, the Benefit Year Deductible (see page 13) will not apply to services provided by a *participating provider* that have a set-dollar Co-Payment, including office visits to *physicians*, *emergency* or urgent care, physical therapy, physical medicine, occupational therapy, speech therapy, chiropractic services, acupuncture, and osteopathic manipulation. However, the Benefit Year Deductible will apply to other charges made during an office visit, such as for testing procedures, surgery, etc.
- The Benefit Year Deductible will not apply to the “Medical Evacuation” and “Repatriation of Remains” benefits.
- With respect to Medical Benefits for Dependents, the Benefit Year Deductible (see page 23) will not apply to the following services: (a) *physician’s* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; (b) the Physical Exam benefit; and (c) services under the Adult Preventive Services benefit.

- The Benefit Year Deductible will not apply to the following immunizations provided by a *participating provider*:
 - a. Diphtheria/Tetanus/Pertussis
 - b. Measles, Mumps and Rubella
 - c. Varicella
 - d. Influenza
 - e. Hepatitis A and Hepatitis B
 - f. Pneumococcal
 - g. Meningococcal
 - h. Polio
 - i. Human Papillomavirus

All other immunizations are subject to the Benefit Year Deductible.

- The Benefit Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *CME*.
- With respect to students, the Benefit Year Deductible (see page 13) will not apply to Transgender Surgery travel expenses authorized by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.
- The Benefit Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant procedure provided at a designated *CME*.

Non-Participating Facility Inpatient Deductible. With respect to Student Medical Benefits, each time you are admitted to a *hospital* or *residential treatment center* which is a *non-participating provider*, you are responsible for paying the Inpatient Deductible (see page 14). This deductible will not apply to an *emergency* admission, or to services for which the *claims administrator* has negotiated a single case payment agreement with the non-participating facility.

CO-PAYMENTS AND CO-INSURANCE

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

For Co-Insurance, the *claims administrator* will apply the applicable percentage to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your Co-Insurance.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Benefit Year Deductible, you pay Co-Insurance equal to your Out-of-Pocket Amount per *member* during a *benefit year*, you will no longer be required to make Co-Insurance payments for any *covered expense* you incur during the remainder of that *year*.

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

- Charges which are not considered *covered expense*;
- Any expense applied to a deductible; and
- Any Co-Payments you make.

In addition, you will continue to be required to pay those Co-Payments, even after the Out-of-Pocket Amount is reached.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums.

CONDITIONS OF COVERAGE

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

1. For students only. You must obtain an authorization from a UHS provider for all services and supplies provided outside of the University Health Services. Expenses will not be covered unless based on prior referral by a UHS provider, except for *urgent care* or *emergency services* for a medical or psychiatric *emergency*.
2. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
3. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
4. 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.
5. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
6. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
7. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
8. All services and supplies must be ordered by a *physician*.
9. The services or supplies must be *medically necessary*, unless the services are provided under the "Well Baby and Well Child Care", "Screenings for Blood Lead Levels", "Adult Preventive Services", "Physical Exam" and "Other Cancer Screenings" benefits.

MEDICAL CARE THAT IS COVERED

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

Adult Preventive Services. FDA-approved cancer screenings for cervical cancer, including human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer, prostate cancer screenings, and the office visit related to those services.

Ambulance. The following *medically necessary* 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. The maximum benefit for air ambulance transportation services is limited to **\$25,000** per *benefit year*.
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.

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

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

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

- Transportation for the *member* to and from the CME up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the CME up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

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

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 whether due to illness or injury, including:

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially with Adult Preventive Services benefits (see "Adult Preventive Services").
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").

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

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

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

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

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs 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 the *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

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

Chemotherapy

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

1. Services of a chiropractor for manual manipulation of the spine to correct subluxation.

2. Manipulation therapy services provided by an osteopath.
3. 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 combined maximum for all services will be limited to 20 visits during a *benefit year*.

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

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

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 *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental 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. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
 - e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

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

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

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

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

- 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.

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

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

- 1. Of no further use when medical needs end;
- 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. Our payment for rental or purchase will not exceed **\$5,000** per *benefit year*, not including durable medical equipment provided by a *home infusion therapy provider*.

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

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

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

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

No benefits will be provided for the following:

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

NOTE: Hearing aids are not covered if provided by a *non-participating provider*.

Hemodialysis Treatment

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

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

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

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.

If the *claims administrator* applies *covered expense* toward the Benefit Year Deductible and the *plan* does not provide payment, those visits will be included in the 100 visits for that year.

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

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

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

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

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

Hospice Care. We will pay up to a maximum of **\$5,000** per *benefit year* 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. Bereavement counseling for your family, limited to four visits in the 12-month period after your death. Benefits are limited to **\$25** for each visit.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

Hospital

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.

Immunizations. The following immunizations are covered under this *plan*:

- Diphtheria/Tetanus/Pertussis, administered together or individually
- Measles, Mumps and Rubella

- Varicella
- Influenza
- Hepatitis A and Hepatitis B, administered together or individually
- Pneumococcal
- Meningococcal
- Polio
- Human Papillomavirus (female and male)
- Japanese Encephalitis
- Typhoid
- Yellow Fever
- Rabies

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

Medical Evacuation. For *members* who are studying or traveling abroad or international students in the U.S. on a non-immigrant visa, benefits will be paid toward reimbursement of the expenses incurred transporting you back to your country of legal residence for medical care and treatment. We will pay medical evacuation benefits if: (a) your illness commenced or injury occurred while you were covered by this *plan*; (b) your physician certifies in writing that you are medically stable and you require further care and treatment for your accident or illness; and (c) you have incurred expenses for your transportation back to your country of legal residence for your medical care and treatment. The total amount of benefit for medical evacuation is **\$10,000**.

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

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

3. The cost of airfare for a family member or traveling companion accompanying you.

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

http://atyourservice.ucop.edu/employees/health_welfare/biz_trvl_accident.html

Please note that in order to receive coverage for this benefit (which includes medical evacuation and repatriation of remains while studying and researching in a foreign country) you MUST register prior to your trip. Registration is simple and takes less than 5 minutes. You may register here:

<https://www.uctrips-insurance.org/servlet/guest?service=0&formId=2>

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

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

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section, services from a *residential treatment center*, and visits to a *day treatment center*.
2. *Physician* visits during a covered inpatient *stay*.
3. Outpatient medication management by a psychiatrist.
4. *Physician* visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders* or substance abuse. For non-UHS/CAPS (University Health Services/Counseling and Psychological Services) services, outpatient *physician* visits will require pre-service review after the first 12 visits. No benefits are payable if pre-service review is not obtained for visits after the 12th visit. (See UTILIZATION REVIEW PROGRAM.)

Treatment for substance abuse does not include smoking cessation programs.

Neuropsychological Testing. Neuropsychological testing by a neuropsychologist for ADD (attention deficit disorder) or ADHD (attention deficit hyperactivity disorder) diagnosis, treatment, and determination of academic accommodation.

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.

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

1. Nebulizers, including face masks and tubing. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment and Prosthetic Devices").
2. Inhaler spacers and peak flow meters. These items are covered under your *prescription drug* benefits and are subject to the Co-Payment for *brand name drugs* (see YOUR PRESCRIPTION DRUG BENEFITS).
3. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Physical Exam. In addition to any services specified elsewhere in the booklet, we will pay for the following services:

1. A *physician's* services for an annual routine physical examination.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with an annual routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

Prostate cancer screenings, cervical cancer screenings including human papillomavirus (HPV) screening, breast cancer screenings, and other cancer screenings are not provided under this "Physical Exam" benefit but are provided under the medical care provisions of this *plan* as described under "Adult Preventive Services", "Breast Cancer" and "Other Cancer Screening Tests".

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

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

For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Our maximum payment for all services combined is limited to **\$5,000** per *benefit year*.

Post-exposure Prophylaxis (students only). Post-exposure prophylaxis following exposure to bodily fluids while engaging in an activity required by your academic program. Services must be *medically necessary* as determined by the clinical guidelines of the facility in which the exposure takes place.

Pregnancy and Maternity Care

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

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

2. All covered services for the newborn child's first 31 days after birth will be covered at the benefit level of the *member*, if the *member* is

the child's natural parent and the *plan* has been notified of the child's birth. If the *child* is not enrolled as a covered *dependent* within 31 days of birth, the maximum we will pay is **\$25,000** for all covered services provided during that 31-day period.

Professional Services

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

Prosthetic Devices

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

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. For *members* who are studying or traveling abroad or international students in the U.S. on a non-immigrant visa, benefits will be paid toward reimbursement of the expenses incurred by the person or persons preparing and transporting your remains to your country of legal residence. We will pay benefits if your death occurs while you were covered by this *plan* and one or more persons have incurred expense for the preparation and transportation of your remains to your country of legal residence for burial. The total amount of benefits for the repatriation of your remains will be **\$7,500**.

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*.

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*.

If the *claims administrator* applies *covered expense* toward the Benefit Year Deductible and the *plan* does not provide payment, those days will be included in the 100 days for that year.

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 under this *plan's prescription drug* benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a *pharmacy* are covered as medical supplies under this *plan's* medical benefits.

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

Transgender Surgery Benefits For Students. This *plan* provides benefits to *insured students* for many of the charges incurred 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 services are authorized (See UTILIZATION REVIEW PROGRAM for details), this *plan* will provide *medically necessary* benefits in connection with transgender surgery.

We do not make benefit payments for any *member* in excess of the Transgender Surgery Lifetime Maximum of **\$75,000.00** (including Transgender Surgery Travel Expense).

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.

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

1. The recipient; or
2. The donor.

If you are the recipient, an organ or tissue donor who is not an enrolled *member* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. *Covered expense* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. *Reasonable charges* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

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

SPECIFIED TRANSPLANTS:

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

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

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

Well Baby and Well Child Care. The following services for a dependent *child* under 19 years of age:

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations.

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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.

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

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

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

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, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. 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 implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

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

Education or Counseling. Any educational treatment or nutritional counseling, or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the *claims administrator*. Such services are provided under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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

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

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

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

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

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

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

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

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

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

Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation, except as specifically stated in the "Neuropsychological Testing" provision of MEDICAL CARE THAT IS COVERED. Any treatment of *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" provision of MEDICAL CARE THAT IS COVERED. Any educational treatment or any services that are

educational, vocational, or training in nature except as specifically provided or arranged by the *claims administrator*.

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

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

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined. For the purposes of the Transgender Surgery Benefit For Students, if you meet the conditions of coverage under the "Transgender Surgery Benefits For Students" provision of MEDICAL CARE THAT IS COVERED, and the services and supplies for your transgender surgery are authorized by the *claims administrator* (See UTILIZATION REVIEW PROGRAM for details), this exclusion will not apply to those services and supplies.

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

Optometric Services or Supplies. Optometric services are covered under a separate Vision Plan. Eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Physical Exam" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Orthodontia. Braces and other orthodontic appliances or services.

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the YOUR PRESCRIPTION DRUG BENEFITS section of this booklet and under the "Home Infusion Therapy" and "Therapeutic/Elective Abortion" provisions of MEDICAL CARE THAT IS COVERED section. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

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

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

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

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by the DMV, for voluntary participation in any academic, recreational or other program, for employment or by government authority, except as specifically stated in the "Well Baby and Well Child Care", "Physical Exam", "Adult Preventive Services", "Breast Cancer" or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

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

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

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex except as specifically stated in the "Transgender Surgery Benefits For Students" provision of MEDICAL CARE THAT IS COVERED.

Sports Related Conditions. Expenses incurred for treatment of sport-related *accidental injury* resulting from intercollegiate or professional sports.

Sterilization Reversal. Reversal of sterilization.

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

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

Unauthorized Services. With respect to students only: Except as otherwise provided in this Benefit Booklet, services not approved by University Health Services. Also, this exclusion does not apply to *urgent care* or *emergency* room care.

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

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

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

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.
 - 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 the *claims administrator* 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 such notice or to cooperate with the *claims administrator*, 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.

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

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS AND CO-INSURANCE

After the *pharmacy benefits manager* determines *prescription drug covered expense*, they will subtract your Prescription Drug Co-Payment for each *prescription*.

If you owe a Co-Insurance amount, then the *pharmacy benefits manager* will apply the Co-Insurance amount to the *prescription drug covered expense*. This will determine the dollar amount of your Prescription Drug Co-Insurance.

The Prescription Drug Co-Payments and Co-Insurance amounts are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

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

For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) or log on to www.ucop.edu/ucship to find a provider near you.

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

**Prescription Drug Program
Attn: Claims Department
P.O. Box 66583
St. Louis, MO. 63166-6583**

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

When You Go to a Non-Participating Pharmacy (Not applicable to *dependents*). If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to the *claims administrator*, at the address below:

**Prescription Drug Program
Attn: Claims Department
P.O. Box 66583
St. Louis, MO. 63166-6583**

Non-participating pharmacies do not have the necessary prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it.

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

IMPORTANT NOTE: *Prescriptions for dependents* that are filled at *non-participating pharmacies* are not covered under this *plan*.

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

When You Order Your Prescription Through the Mail (Note: the Mail Order Program applies to dependents only.)

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

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

Order forms can be obtained by contacting:

Prescription Drug Program - Mail Service
P.O. Box 66558
St. Louis, MO. 63166-6558
1-866-274-6825

When You Order Your Prescription Through the Specialty Drug Program. (NOTE: The Specialty Drug Program applies to dependents only. Students may obtain drugs listed as *specialty drugs* as any other formulary medication.) You can only order your *prescription* for a *specialty drug* through the Specialty Drug Program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). Anthem Blue Cross Life and Health – Specialty Drug Program only fills *specialty drug prescriptions*. Anthem Blue Cross Life and Health – Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health).

The *prescription* for the *specialty drug* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*.

You or your *physician* may order your *specialty drug* by calling 1-877-241-3489. When you call Anthem Blue Cross Life and Health – Specialty Drug Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty drug* to you. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your *specialty drug prescription* with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross Life and Health – Specialty Drug Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment or Co-Insurance amount.

The first time you get a *prescription* for a *specialty drug* you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number. Co-Payments and Co-Insurance payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty drugs* available through Specialty Drug Program or order forms by contacting Member Services at the number shown below or online at www.ucop.edu/ucship.

**Specialty Drug Program
Attn: Claims Department
P.O. Box 66583
St. Louis, MO. 63166-6583**

If you are a *dependent* and you don't get your *specialty drug* through the Specialty Drug Program, you will not receive any benefits under this *plan* for them.

PRESCRIPTION DRUG FORMULARY

IMPORTANT NOTE: The following pertains to *prescription drugs* obtained outside the UHS pharmacies; the formulary is not used at University Health Services pharmacies.

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

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

PRESCRIPTION DRUG CONDITIONS OF SERVICE

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.

2. It must be approved for general use by the State of California Department of Health Services or the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs prescribed for cosmetic purposes are not included. However formulas prescribed by a *physician* for the treatment of phenylketonuria are covered.
4. It must be dispensed from an UHS pharmacy, a licensed retail *pharmacy*, through the mail service program or, with respect to *dependents* only, through the Specialty Drug Program.
5. **If it is an approved *compound medication*, be dispensed by a *participating pharmacy*.** Call 1-800-700-25411 (or TTY/TDD 1-800-905-9821) to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a *participating pharmacy* at www.ucop.edu/ucship) **You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.**
6. **If it is a *specialty drug*, be obtained by using the Specialty Drug Program.** (For insured *dependents* only) See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY DRUG PROGRAM for how to get your *drugs* by using the Specialty Drug Program. **You will have to pay the full cost of any *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the Specialty Drug Program. If you order a *specialty drug* through the mail service program, it will be forwarded to the Specialty Drug Program for processing and will be processed according to Specialty Drug Program rules.**

Exceptions to Specialty Drug Program. This requirement does not apply to:

- a. *Members* who are covered under this *plan* as students;
- b. The first two months' supply of a *specialty drug* which is available through a *participating pharmacy*;
- c. *Drugs*, which due to medical necessity, must be obtained immediately; and
- d. A *member* who is unable to pay for delivery of their medication (i.e., no credit card).

How to obtain an exception to the Specialty Drug Program. If you believe that you should not be required to get your medication

through the Specialty Drug Program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to the *claims administrator*. The form can be faxed or mailed to the *claims administrator*. If you need a copy of the form, you may call the *claims administrator* at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. You can also get the form on-line at www.ucop.edu/ucship. If the *claims administrator* has given you an exception, it will be in writing and will be good for 12 months from the time it is given. After 12 months, if you believe that you should still not be required to get your medication through the Specialty Drug Program, you must again request an exception. If the *claims administrator* denies your request for an exception, it will be in writing and will tell you why they did not approve the exception.

Urgent or emergency need of a *specialty drug* subject to the Specialty Drug Program. If you are out of a *specialty drug* which must be obtained through the Specialty Drug Program, the *claims administrator* will authorize an override of the Specialty Drug Program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your *physician* decides that it is appropriate and *medically necessary*. You may have to pay the applicable Co-Payment or Co-Insurance amount shown under SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS AND CO-INSURANCE for the 72-hour supply of your *drug*.

If you order your *specialty drug* through the Specialty Drug Program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the *drug* immediately, the *claims administrator* will authorize an override of the Specialty Drug Program requirement for a 30-day supply or less, to allow you to get an emergency supply of medication from a *participating pharmacy* near you. A Dedicated Care Coordinator from the Specialty Drug Program will coordinate the exception and you will not be required to make an additional Co-Payment or Co-Insurance payment.

7. It must not be used while you are confined in a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*. Also, it must not be dispensed in or administered by a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanatorium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

8. For a retail *pharmacy* or through the Specialty Drug Program, the *prescription* must not exceed a 30-day supply.

Prescription drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of Co-Payment or Co-Insurance amount for retail *pharmacies*. If the *drugs* are obtained through the mail service program, the Co-Payment or Co-Insurance amount will remain the same as for any other *prescription drug*.

9. For the mail service program, the *prescription* must not exceed a 90-day supply.
10. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the Co-Payment for *brand name drugs*.
2. Insulin.
3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.
4. NuvaRing, subject to the Co-Payment for *formulary brand name drugs*.
5. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year* and are subject to the Co-Payment for *brand name drugs*.
6. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient, or administered to the patient by a family member. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
7. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.
8. Diabetic supplies (i.e. test strips and lancets).

9. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the Co-Payment for *brand name drugs*.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this *prescription drug* benefit, these items are covered under the "Blood," "Well Baby and Well Child Care," and "Preventive Care or Physical Exam," provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "Hospice Care," "Infusion Therapy or Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "Prescription Drug for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.
4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Hospital," "Home Health Care," "Hospice Care," and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
5. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug*

benefit, these services are covered as specified under the “Professional Services” and “Infusion Therapy or Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications which may be obtained without a *physician’s* written *prescription*, except insulin or niacin for cholesterol lowering.
7. *Drugs* and medications dispensed by or while you are confined in a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the “Hospital”, “Skilled Nursing Facility”, and “Hospice Care”, provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanatorium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the “Professional Services” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanatorium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.
8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive devices as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the “Durable Medical Equipment and Prosthetic Devices”, “Hearing Aid Services”, and “Diabetes” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
9. Services or supplies for which you are not charged.
10. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the “Hospital”, “Skilled Nursing Facility”, “Home Health Care” and “Hospice Care” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

11. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment and Prosthetic Devices" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.
12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because the *claims administrator* determines that the *drug* is *experimental* or *investigative*, you may appeal the decision by calling the *claims administrator* at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).
13. Any expense incurred for a *drug* or medication in excess of the *prescription drug maximum allowed amount*.
14. *Drugs* which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.
15. Over-the-counter smoking cessation *drugs*. This does not apply to *medically necessary drugs* that you can only get with a *prescription* under state and federal law.
16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.
17. *Drugs* used primarily for the purpose of treating infertility, unless *medically necessary* for another covered condition.
18. Anorexiant and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).
19. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
20. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion

Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

21. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the “Special Food Products” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.
22. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.
23. *Compound medications* obtained from other than a *participating pharmacy*. **You will have to pay the full cost of the *compound medications* you get from a *non-participating pharmacy*.**
24. For insured *dependents* only, *specialty drugs* that must be obtained from the Specialty Drug Program, but, which are obtained from a retail *pharmacy* are not covered by this *plan*. **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the Specialty Drug Program. If you order a *specialty drug* through the mail service program, it will be forwarded to the Specialty Drug Program for processing and will be processed according to Specialty Drug Program rules.**

EXCESS COVERAGE

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

UTILIZATION REVIEW PROGRAM

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

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

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your *dependents*.

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions.
- *Facility-based care* for the treatment of *mental or nervous disorders*, and substance abuse.
- Transplant services.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.

- Bariatric surgical services performed at a *Centers of Medical Excellence (CME)* facility.
- For non-UHS-CAPS (University Health Services/Counseling and Psychological Services) services, outpatient visits to a *physician* for the treatment of *mental or nervous disorders* or substance abuse after the first 12 visits in a *year*.
- Transgender Surgery Benefits For Students services.

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 or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
 - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
 - *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.
 - Transplant services.
 - Home infusion therapy.
 - Home health care.
 - Admissions to a *skilled nursing facility*.
 - Bariatric surgical services performed at a *CME* facility.
 - For non-UHS-CAPS (University Health Services/Counseling and Psychological Services) services, outpatient visits to a *physician* for the treatment of *mental or nervous disorders* or substance abuse after the first 12 visits in a *year*.
 - Transgender Surgery Benefits For Students services.

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 not performed as required for an inpatient *hospital* or *residential treatment center* admission, or for *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse, **benefits will not be provided for those services.**
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Transplant services as follows:
 - a. For bone, skin or cornea transplants, if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Medical Excellence (CME)* facility.
 - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
 - Home health care services if:
 - a. The services can be safely provided in your home, as certified by your attending *physician*;

- b. Your attending *physician* manages and directs your medical care at home; and
 - c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
- Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:
 - a. The services are to be performed for the treatment of morbid obesity;
 - b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
 - c. The bariatric surgical procedure will be performed at a *CME* facility.
- For non-UHS-CAPS (University Health Services/Counseling and Psychological Services) services, outpatient visits to a *physician* for the treatment of *mental or nervous disorders* or substance abuse after the first 12 visits in a *year*.
- Transgender surgery services for *insured students* and related covered services will be provided as follows:
 - a. The Surgical Procedure:
 - i. The services are *medically necessary* and appropriate; and
 - ii. 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*; and
 - 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.**

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

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed, benefits will not be provided as shown in the “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 reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. The *claims administrator* will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, the *claims administrator* will, if appropriate, specify a specific length of *stay* for services. For *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse, 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 by the review coordinator as *medically necessary*.
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 to 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 *claims administrator* employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your *plan* identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

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

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

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

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

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, the *claims administrator* has the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. The *plan* 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 *claims administrator* has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member*, which alternatives may be offered and the terms of the offer.
3. An authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *member*.
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 *member*.

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
2. If you, your representative, or your *physician* acting on your behalf finds the reconsidered decision still unsatisfactory, a grievance or a request for an appeal of reconsidered decision may be submitted in writing to the *claims administrator*.
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 of Anthem Blue Cross Life and Health is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

CONTINUATION OF BENEFITS AFTER TERMINATION

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

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.

Applications for conversion coverage are available at your campus University Health Services.

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, has a program (called the "BlueCard Program") which allows our *members* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, the *claims administrator* must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your co-payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to the *claims administrator*.

Often, the "negotiated price," referred to above, 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 in 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 **average** expected savings with your health care provider or with a

specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over or underestimation of past prices. Regardless of how the negotiated price is determined, 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 *member* 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 statutes mandate *member* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, the *claims administrator* would then calculate your co-payment for any covered health care services using the methods outlined by 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. This *plan* does not have the right to cancel your coverage while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required premiums are paid according to the terms of the *plan*, except as noted under the terms of HOW COVERAGE ENDS.

Free Choice of Provider. This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which

provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from the *claims administrator*, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *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. The *plan* is not liable for any expense you incur in excess of the benefits of this *plan*.

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

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

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. The benefits of this *plan* will be paid directly to *contracting hospitals*, *participating providers*, *CME* and medical transportation providers. If you receive services from *non-contracting hospitals* or *non-participating providers*, payment will be made directly to the student and you will be responsible for payment to the provider. In some cases a *non-participating provider* may be willing to submit claims on behalf of the member to the *claims administrator*, in which case the

student would have to sign a statement assigning benefits to the provider. The *plan* will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your *dependents*. The *plan* will continue such direct payment until the emergency care results in stabilization. These payments will fulfill the *plan's* obligation to you for those covered services.

Right of Recovery. When the amount paid exceeds the *plan's* liability, the *plan* has 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 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*.

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

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. The *claims administrator* 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.

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a provider who was a member of your prior plan's network but is a *non-participating provider* under this *plan*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this *plan*.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls in this *plan*.
6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this *plan*.

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

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, Co-Insurance, and Co-Payments under the *plan*. Financial arrangements with *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 Co-Payments, Co-Insurance, deductibles and other terms) received from a provider at the time the provider's contract with the *claims administrator* terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *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, including reimbursement rate, of his or her agreement with the *claims administrator* prior to termination. If the provider does not agree with these contractual terms and conditions, the provider's services will not be continued beyond the contract termination date.

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1)

year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, Co-Insurance, and Co-Payments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to *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.

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

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

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

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

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

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

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

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of, or 30 minutes normal travel time from, your residence or place of work or study;
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*.

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a bariatric *CME*.

Note: An *authorized referral* is not in lieu of an UHS referral.

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

Benefit year is a 12-month period that determines the application of your benefits, such as the accumulation toward satisfaction of the annual deductible, accumulation toward annual benefit limitations or maximums,

and accumulation toward the annual out-of-pocket liability maximum. Benefit year dates vary by campus – check with University Health Services for the dates of your benefit year.

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

Centers of Medical Excellence (CME) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept *negotiated rate* as payment in full for covered services. A *participating provider* in the Prudent Buyer Plan network is not necessarily a *CME*.

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

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

Compound Medication is a mixture of *prescription drugs* and other ingredients, of which at least one of the components is commercially available as a prescription product. Compound medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or
2. Products lacking a National Drug Code (NDC) number.

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

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

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 set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

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

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

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

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

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.

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

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

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

Drug (prescription drug) means a drug approved by the State of California Department of Health or 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), or a *psychiatric emergency medical condition*, which the *member* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

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

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

Facility-based care is care provided in a *hospital, psychiatric health facility, residential treatment center* or *day treatment center* for the treatment of *mental or nervous disorders* or substance abuse.

Formulary drug is a *drug* listed on the *prescription drug formulary*.

Generic prescription drug (generic drug) is a pharmaceutical equivalent of one or more *brand name drugs* and must be approved by

the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the *brand name drug*.

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

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

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

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

For the limited purpose of inpatient care for the acute phase of a *mental or nervous 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 is a person who, by meeting the *plan's* eligibility requirements for an eligible student, is enrolled under this *plan*. The insured student may elect coverage for his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

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

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

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

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

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.

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

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

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

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. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare’s approved amount (see HOW COVERED EXPENSE IS DETERMINED).

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

Non-participating pharmacy is a *pharmacy* which does not have a contract in effect with the *pharmacy benefits manager* at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

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*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

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

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

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;
8. A clinical laboratory; or
9. A home infusion therapy provider.

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.

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

Physician means:

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

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

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

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

Prescription drug covered expense is the expense you incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

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

Prescription drug formulary (formulary) is a list which the *claims administrator* has developed of outpatient *prescription drugs* which may

be cost-effective, therapeutic choices. Any *participating pharmacy* can assist you in purchasing *drugs* listed on the formulary. You may also get information about covered formulary drugs by calling 1-800-700-254 or going to the *claims administrator's* internet website anthem.com/ca.

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

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

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

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

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

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

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

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 *member* 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* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders* or rehabilitative treatment of substance abuse according to state and local laws.

Routine physical examination is a visit to a *physician* in the absence of a specific medical concern, for the purposes of screening for diseases, assessing risk of future medical problems, encouraging a healthy lifestyle through educational intervention, and updating vaccinations. One routine physical exam per plan year provided at University Health Services will be covered at 100%. Physical exams for the purposes of employment or for clearance for participation in governmental, academic, recreational or other programs or services are not covered by the *plan*.

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

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

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

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These *drugs* often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail *pharmacies*.

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

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

Transplant Centers of Medical Excellence negotiated rate (CME negotiated rate) is the fee *CME* agree to accept as payment for covered services. It is usually lower than their normal charge. CME negotiated rates are determined by Centers of Medical Excellence Agreements.

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

FOR YOUR INFORMATION

24/7 NurseLine

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

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

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

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

Future Moms

Future Moms is a free program available to Graduate Students and their dependents who are pregnant members up to 34 weeks gestation. If you wish to enroll in the Future Moms program, please contact Anthem Blue Cross at **800-769-4896**. Information you provide will allow Anthem Blue Cross' specialized nurses to review and assess your potential for having a high risk pregnancy.