



**PEPPERDINE UNIVERSITY
HEALTH & WELFARE PLAN**

September 1, 2007



Prudent Buyer Exclusive Plan

**COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM**

**Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367**

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. Your employer will provide you with a copy of the health plan contract upon request.

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TYPES OF PROVIDERS

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

Participating Providers. We have established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO), which we call the Prudent Buyer Plan. They have agreed to provide our members with health care at a special low cost. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

All care must be provided, or coordinated by, a *participating provider physician*.

We publish a directory of Participating Providers. You can get a directory from your plan administrator (usually your employer) or from us. 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 us at the customer service number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at www.bluecrossca.com.

Non-Participating Providers. *Non-participating providers* are particular providers which are types of providers included in the Prudent Buyer network, but, have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the *negotiated rates* and other provisions of a Prudent Buyer Plan contract. **Benefits are provided for them under the plan only if you have an *authorized referral*, for an *emergency* or for *urgent care*.**

In addition, if you are a new *member* who enrolled in this *plan* as a result of the *group* changing health plans, and you are receiving services for an acute, serious, or chronic *mental or nervous disorder* from a *non-participating provider*, you may be able to continue your course of treatment with *the non-participating provider* for a reasonable period of time prior to transferring to another provider who participates in the Prudent Buyer Plan network. To request this continued care or to get a copy of our written policy for this continued care, please call us at the customer service telephone number listed on your ID card.

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 we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of our 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* contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Member Rights and Responsibilities. Blue Cross of California is committed to maintaining a mutually respectful relationship with our *members*, and at the same time we expect our *members* to assume certain responsibilities. Your Member Rights and Responsibilities are described below and your rights, our legal duties, and our privacy

practices related to HIPAA are described in our "Notice of Privacy Practices" found on our website at <http://www.bluecrossca.com> or by calling the customer service telephone number on your ID card.

Member Rights. You have the right to:

- Receive clear and accurate information about Blue Cross of California, your rights and responsibilities, your health plan benefits and services, and how and when you can use them;
- Receive the names and contact information of participating doctors, *hospitals*, pharmacies, and other health care providers available to you;
- Be treated with courtesy, respect, and dignity;
- Your privacy and to have your personal health information be kept secure and confidential;
- Be involved with doctors and other health care professionals in decision-making regarding your health care;
- Talk over your health care needs with the health care professionals caring for you, including a clear and open discussion about appropriate or medically necessary care available for your condition, without concern for the cost or whether it is covered by your health plan benefits;
- Make a written or spoken suggestion, expression of dissatisfaction, or complaint about the care or service you received from a participating health professional or provider, or about the service you received from your health plan, and you may appeal any decision made relating to you or your health plan benefits and/or health plan services; and
- Write to Blue Cross of California with ideas or questions about this statement on *member* rights and responsibilities. Your letter can be sent to Quality Improvement Department, Attn: Rights and Responsibilities, Mailstop AC-6G, P.O. Box 70000, Van Nuys, CA 91470-0001.

Member Responsibilities. To assist participating health care professionals and providers in meeting these responsibilities to you, it is your duty to:

- Give patient identification and medical information, to the best of your ability, that your health care professionals and providers need in order to care for you and for your health plan to provide services to you;
- To the best of your ability, work with your doctor to be aware of and understand your health issues so you can participate in developing mutually agreed-upon treatment goals;
- Follow the prescribed medical treatment plan and health care instructions that you have agreed upon with your doctor or other health care professional and tell him or her if you decide to take part in any Blue Cross of California-sponsored health activity or program;
- Treat all health care professionals with courtesy and respect;
- Keep scheduled appointments for care and give adequate advance notice of delay or cancellation; and
- Read and understand to the best of your ability all materials concerning your health benefits or ask for clarification as needed.

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

"Non-Participating Pharmacies" have not agreed to the *prescription drug negotiated rate*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

Centers of Expertise. We have established the following separate *Centers of Expertise* (COE) networks. The facilities included in each of these COE networks provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Subject to any applicable co-payments or deductibles, these COE's agree to accept the *COE negotiated rate* as payment in full for covered services. **These procedures are covered only at a COE.**

- **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 at a COE.**

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

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT BLUE CROSS DETERMINES TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS A COVERED EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE US 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 need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult your employer's health plan contract with Blue Cross to determine the exact terms and conditions of your coverage.

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

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

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

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductible**\$100**
- Family Deductible**three Member Deductibles**

Additional Deductible

- Emergency Room Deductible.....**\$100**

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

- The Calendar Year Deductible 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; and (b) the Physical Exam benefit.
- The Calendar Year Deductible will not apply to office visits to a *physician*, if those visits are for treatment for other than *mental or nervous disorders* or substance abuse.

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

- The Calendar Year Deductible will not apply to diabetes education program services provided by a *physician*.
- The Calendar Year Deductible will not apply to services under the Adult Preventive Services benefit.
- The Calendar Year Deductible will not apply to transplant travel expenses in connection with an authorized transplant procedure provided at an approved COE.
- The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at an approved COE.
- The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.

CO-PAYMENTS

Co-Payment.* After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for **10%** of *covered expense* you incur.

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

*Exceptions:

- Your Co-Payment for a routine examination under the Well Baby and Well Child Care benefit 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. There will be no Co-Payment for immunizations under the Well Baby and Well Child Care benefit.
- Your Co-Payment for services under the Physical Exam benefit will be **\$15**. This Co-Payment will not apply toward satisfaction of any deductible, nor will it apply toward satisfaction of the Out-Of-Pocket Amount.
- Your Co-Payment for office visits to a *physician* who is a *participating provider*, for treatment for other than *mental or nervous disorders* or substance abuse, 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 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.
- No Co-Payment will be required for the transplant travel expenses authorized by us. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.
- Co-Payments do not apply for bariatric travel expenses authorized by us. Bariatric travel expense is available when the closest COE is in excess of 50 miles from the *member's* residence.

Out-of-Pocket Amount*. After each *member* has made **\$1,000** of out-of-pocket payments for *covered expense* incurred during a *calendar year*, each *member* will no longer be required to pay a Co-Payment for the remainder of that *calendar year*, but will remain responsible for costs in excess of *covered expense*.

***Exceptions:**

- Any Co-Payments you make for the treatment of *mental or nervous disorders* or substance abuse (except *severe mental disorders*) will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such treatment even after you have reached that amount.
- Any Co-Payments you make for routine examinations under the Well Baby and Well Child Care benefit, when such care is provided by 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 your Co-Payment for such care even after you have reached that amount.

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

- Your Co-Payment for office visits to a *physician* who is 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 your Co-Payment for such visits even after you have reached that amount.
- Your Co-Payment for diabetes education program services provided by a *physician* who is 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 your Co-Payment for such 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 calendar year

Home Health Care

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

Durable Medical Equipment

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

Mental or Nervous Disorders

- For covered *physician's services* **\$40**
per visit
- For covered *facility-based care* **\$500**
per day

Substance Abuse

- For covered *physician's services* **\$40**
per visit, for up to 50
visits per calendar year
- For covered *facility-based care* **\$500**
per day, for up to 30
days per calendar year

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

Physical Exam (Members Age 7 and Over)

- For all covered services and supplies **\$250**
per calendar year

Physical Therapy, Physical Medicine and Occupational Therapy

- For covered outpatient services **48**
per calendar year,
additional visits as authorized
by us if *medically necessary*

Acupuncture

- For all covered services..... **\$30**
per visit, for up to 12 visits
per calendar year

Transplant Travel Expense

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

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 *COE* 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 *COE* 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 and drug expenses) up to **\$25**
per day,
for up to 4 days per trip

Lifetime Maximum

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

PRESCRIPTION DRUG BENEFITS

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

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

Participating Pharmacies

- *Generic Drugs*\$10
- *Brand Name Drugs:*
 - *Formulary drugs* and *non-formulary drugs* when the prescriber has specified “dispense as written”\$20
- *Non-formulary brand name drugs*\$40
- *Compound medications*.....\$40
- Self-administered injectable drugs, except insulin20%
of *prescription drug covered expense*
to a maximum copayment of **\$100**
for each prescription

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 us.

Non-Participating Pharmacies*

- *Generic Drugs* **\$10**
plus **50%** of the remaining *prescription drug covered expense*

- *Brand Name Drugs:*
 - *Formulary drugs and non-formulary drugs*
when the prescriber has specified
“dispense as written” **\$20**
plus **50%** of the remaining *prescription drug covered expense*

- *Non-formulary brand name drugs* **\$40**
plus **50%** of the remaining *prescription drug covered expense*

- Self-administered injectable
drugs, except insulin **20%**
of *prescription drug covered expense*
to a maximum copayment of **\$100** for each *prescription*
plus **50%** of the remaining *prescription drug covered expense*

Mail Order Prescriptions: The following co-payments apply for a 90-day supply of medication.

- *Generic Drugs* **\$10**

- *Brand Name Drugs:*
 - *Formulary drugs and non-formulary drugs*
when the prescriber has specified
“dispense as written” **\$20**

- *Non-formulary brand name drugs* **\$40**

- Self-administered injectable
drugs, except insulin **20%**
of *prescription drug covered expense*
to a maximum copayment of **\$100**
for each *prescription*

Specialty Pharmacy Drug Prescriptions: The following co-payments apply for a 30-day supply of medication obtained from the specialty pharmacy program.

- *Generic Drugs* **\$10**
- *Brand Name Drugs:*
 - *Formulary drugs and non-formulary drugs*
when the prescriber has specified
“dispense as written” **\$20**
- *Non-formulary brand name drugs* **\$40**
- Self-administered injectable
drugs, except insulin **20%**
of *prescription drug covered expense*
to a maximum copayment of **\$100**
for each prescription

***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*.

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

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

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

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

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

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

Non-Participating Providers (Only with an *authorized referral*, for an *emergency*, or for *urgent care*) 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 the *maximum allowable charge*. You will be responsible for any billed charge which exceeds the *maximum allowable 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*.

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

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

DEDUCTIBLES

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.

Calendar Year Deductible. Each *year*, you will be responsible for satisfying the *member's* Calendar Year Deductible before we begin to pay benefits.

Family Deductible. The first three *members* of an enrolled family who satisfy their Calendar Year Deductibles will satisfy the Family Deductible. Once the Family Deductible is satisfied, no further Calendar Year Deductible expense will be required for any enrolled member of that family. However, we will not credit any expense previously applied to the Calendar Year Deductible of any other member of the family.

Prior Plan Calendar Year Deductibles. If you were covered under the *prior plan* any amount paid during the same *calendar year* toward your calendar year deductible under the *prior plan*, will be applied toward your Calendar Year Deductible under this *plan*; provided that, such payments were for charges that would be *covered expense* under this *plan*.

Additional Deductible

Emergency Room Deductible

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

CO-PAYMENTS

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

If your Co-Payment is a percentage, we 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-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments equal to your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make Co-Payments for any *covered expense* you incur during the remainder of that *calendar year*, other than for *covered expense* incurred for treatment of *mental or nervous disorders* or substance abuse (except *severe mental disorders*), routine examinations provided by a *participating provider* under the Well Child Care benefit, services by a *participating provider* under the Physical Exam benefit, office visits to a *physician* who is a *participating provider*, and diabetic education program services provided by a *physician* who is a *participating provider*.

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;
- Charges incurred for services and supplies from a *non-participating provider* without an *authorized referral* unless in connection with an *emergency* or *urgent care*;
- Charges for services for the treatment of *mental or nervous disorders* or substance abuse (except *severe mental disorders*);
- Charges for routine examinations provided by a *participating provider* under the Well Baby and Well Child Care benefit;
- Charges by a *participating provider* under the Physical Exam benefit;
- Charges for office visits to a *physician* who is a *participating provider*; and
- Charges for diabetic education program services provided by a *physician* who is a *participating provider*.

In addition, you will continue to be required to pay your Co-Payment for the treatment of *mental or nervous disorders* or substance abuse (except *severe mental disorders*), Well Baby and Well Child Care provided by a *participating provider*, office visits to a *physician* who is a *participating provider*, services by a *participating provider* under the Physical Exam benefit, and diabetic education program services provided by a *physician* who is a *participating provider* 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. Any Lifetime Maximum under this *plan* will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by Blue Cross, or any of its affiliates, which is sponsored by the *group*.

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

CONDITIONS OF COVERAGE

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

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *participating provider physician* or a *non-participating provider physician* with an *authorized referral*.

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:

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 Blue Cross and the *hospital*, or unless your *physician* orders, and Blue Cross 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.

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

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

Note: *Facility-based care* for the treatment of substance abuse is limited to 30 days per *calendar year*. Any days you spend as an inpatient in a *residential treatment center* will be counted against both this 30 day limit and the 100 day limit applicable to benefits for services provided by a *skilled nursing facility*.

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 *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *employee's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

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

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

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

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

Professional Services

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

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

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

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Certain imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

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.

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.

We will determine whether the item satisfies the conditions above. Our payment for rental or purchase will not exceed **\$5,000** per *calendar year*, not including durable medical equipment provided by a *home infusion therapy provider*.

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").
2. Inhaler spacers and peak flow meters. These items are covered under your *prescription drug* benefits and are subject to the copayment 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*.

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

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *member* is

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

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not *accidental injury*.

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. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is a *subscriber*, an enrolled *spouse*, or a *domestic partner*.

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

1. The organ or tissue recipient; or
2. The organ or tissue 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 does not include charges for services received without first obtaining our prior authorization, or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

You must obtain our prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to preoperative tests and postoperative care. Specified organ transplants must be performed at a *Center of Expertise*

(COE). **Charges for services provided for or in connection with a specified organ transplant performed at a facility other than a COE will not be considered covered expense.** 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 COE only when the recipient or donor's home is more than 250 miles from the specific COE, provided the expenses are approved by us 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 COE, 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.
2. For the donor, per transplant episode, limited to one trip:
 - a. Round trip coach airfare to the COE, not to exceed **\$250**.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 7 days.
 - c. Other expenses, such as meals, not to exceed **\$25** per day, for up to 7 days.

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 COE 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 COE 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 COE. All travel expenses must be approved by Blue Cross in

advance. The fifty (50) mile radius around the COE will be determined by the *bariatric COE coverage area*. (See DEFINITIONS.)

- Transportation for the *member* to and from the COE 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 COE 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. 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 COE. 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.

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

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*, limited to our maximum payment of **\$500** per day.
2. Visits to a *day treatment center*, limited to our maximum payment of **\$500** per day.

3. *Physician* visits during a covered inpatient *stay* or for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders*. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders*. All *physician* visits are limited to our maximum payment of **\$40** for each visit.

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

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

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*, limited to our maximum payment of **\$500** per day.
2. Visits to a *day treatment center*, limited to our maximum payment of **\$500** per day.
3. *Physician* visits during a covered inpatient *stay* or for outpatient treatment of substance abuse. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy). All *physician* visits are limited to our maximum payment of **\$40** for each visit, and a combined total of 50 visits per *calendar year*.

The combined maximum for inpatient *hospital* and *residential treatment center* services and visits to a *day treatment center* will be 30 days during a *calendar year*. This 30 day limit will not apply to inpatient *hospital* services for detoxification during the acute phase of alcoholism or drug dependence.

If we apply *covered expense* toward the *Calendar Year* Deductible, and do not provide payment, that visit is not included in the visit maximum (50 visits) for that *year*. However, if we pay any portion of your *covered expense* for a visit, we do include the visit in the visit maximum.

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

Well Baby and Well Child Care. The following services for a dependent *child* under 7 years of age:

1. A *physician's* services for routine physical examinations. You must pay a **\$15** co-payment for each examination.
2. Immunizations given as standard medical practice for children. You will not have to pay a co-payment for immunizations.
3. Radiology and laboratory services in connection with routine physical examinations.

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*.

Physical Exam (Members Age 7 and Over). We will pay up to **\$250**, after any applicable co-payment, during a *calendar year* for the following services when provided for *members* age 7 and over.

1. A *physician's* services for routine physical examinations. You must pay a **\$15** co-payment for each examination.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

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".

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. The *calendar year* deductible will not apply to these services.

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

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

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

No benefits will be provided for the following:

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

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

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.

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

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *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.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in GRIEVANCE PROCEDURES.

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

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

Up to 48 visits in a *year* for all covered services are payable. But, if we determine that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, we will authorize a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

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

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

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

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

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 12 visits during a *calendar year*, and for up to a maximum of **\$30** for all covered services rendered during each visit.

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 a retail *pharmacy* or through the mail service program (see YOUR PRESCRIPTION DRUG BENEFITS).

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

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

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

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.)

Non-Participating Providers. Services or supplies that are provided by a *non-participating provider* without an *authorized referral*, except *emergency services* or *urgent care*.

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

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

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

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony, 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.

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

Excess Amounts. Any amounts in excess of *covered expense*.

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

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

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

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.

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

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;

3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

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

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

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

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation *drugs*.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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.

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 (Members Age 7 and Over)" and "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Physical Exam (Members Age 7 and Over)" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

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

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

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.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered 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.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

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.

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.

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

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

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

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

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

Education or Counseling. Educational services or nutritional counseling; however, 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.

Food or Dietary Supplements. Food or dietary supplements, except as described under the provisions "Special Food Products" and "Home Infusion Therapy" under MEDICAL CARE THAT IS COVERED.

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Physical Exam (Members Age 7 and Over)", "Breast Cancer", "Screening For Blood Lead Levels" or "Adult Preventive Services" provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

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

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

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

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

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

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.

PRE-EXISTING CONDITION EXCLUSION

No payment will be made for services or supplies for the treatment of a *pre-existing condition*. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your coverage under this *plan*. Generally, this six-month period ends the day before your coverage becomes effective. However if you were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The *pre-existing condition* exclusion does not apply to pregnancy nor to a child who is enrolled in the *plan* within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior *creditable coverage*. Most prior health coverage is *creditable coverage* and can be used to reduce the *pre-existing condition* exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the six-month exclusion period by your *creditable coverage*, you should give us a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you

can show you have *creditable coverage*. Please contact us if you need help demonstrating *creditable coverage*. All questions about the *pre-existing condition* exclusion and *creditable coverage* should be directed to the customer service telephone number listed on your identification card.

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 amount we paid for those services.
 - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
 - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
 - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
 - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
 - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to

facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

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

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

Type of Provider	Maximum Prescription Drug Covered Expense is .
Participating Pharmacies, Mail Service Program, and Specialty Pharmacy Program	Prescription Drug Negotiated Rate
Non-Participating Pharmacies	Drug Limited Fee Schedule Amount

When you choose a *participating pharmacy*, we 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 drug negotiated rate* for the covered services of a *participating pharmacy*.

When we receive a claim for *drugs* supplied by a *non-participating pharmacy*, we first subtract any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *drug limited fee schedule*. The remainder is the amount of *prescription drug covered expense* for that claim.

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

PREScription DRUG CO-PAYMENTS

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

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

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

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

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

Many *participating pharmacies* display an "Rx" decal with our logo in their window. For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541.

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

**Blue Cross of California Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165**

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. Mail your claim, with the appropriate portion completed by the pharmacist, to us within 90 days of the date of purchase. If it is not reasonably possible to

submit the claim within that time frame, an extension of up to 12 months will be allowed.

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

Blue Cross of California Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Non-participating pharmacies do not have our 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. Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

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

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

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

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

Order forms can be obtained by contacting:

Blue Cross of California Prescription Drug Program - Mail Service
P.O. Box 961025
Fort Worth, TX 76161-9863
1-866-274-6825

When You Order Your Prescription Through Specialty Pharmacy.

You can only order your *prescription* for a *specialty pharmacy drug* through the specialty pharmacy program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). Blue Cross of California – Specialty Pharmacy Program only fills *specialty pharmacy drug prescriptions*. Blue Cross of California – Specialty Pharmacy Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Blue Cross of California).

The *prescription* for the *specialty pharmacy 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 pharmacy drug* by calling 1-800-870-6419. When you call Blue Cross of California – Specialty Pharmacy Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty pharmacy drug* to you. (If you order your *specialty pharmacy drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your *specialty pharmacy 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 Blue Cross of California – Specialty Pharmacy 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.

The first time you get a *prescription* for a *specialty pharmacy 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 pharmacy drug prescriptions*, or call the toll-free number. Co-payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty pharmacy drugs* available through specialty pharmacy program or order forms by contacting Member Services at the number shown below or online at www.bluecrossca.com.

Blue Cross of California – Specialty Pharmacy Program
8900 Duke Blvd Ste 100
Mason, OH 45040-8943
Phone 1-800-870-6419
Fax 1-800-824-2642

If you don't get your *specialty pharmacy drug* through the specialty pharmacy program, you will not receive any benefits under this *plan* for them.

PRESCRIPTION DRUG UTILIZATION REVIEW

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

PRESCRIPTION DRUG FORMULARY

We use 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*. These medications, which include both generic and *brand name drugs*, are listed in the *prescription drug formulary*. The *formulary* is updated quarterly to ensure that the list includes *drugs* that are safe and effective. Note: The *formulary drugs* may change from time to time.

Some *drugs* may require prior authorization. If you have a question regarding whether a particular *drug* is on our *formulary drug* list or requires prior authorization please call us at 1-800-700-2541.

Prior Authorization. Certain *drugs* require written prior authorization of benefits in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the *drug* originally requested at the applicable co-payment. (If, when you

first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a *drug* other than the one you are currently taking.) If approved, *drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

In order for you to get a *drug* that requires prior authorization, your *physician* must make a written request to us for you to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be facsimiled or mailed to us. If your *physician* needs a copy of the form, he or she may call us at 1-800-700-2541 to request one. The form is also available on-line at www.bluecrossca.com.

If the request is for urgently needed *drugs*, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- We will review it and decide if we will approve benefits within 72-hours. (As soon as we can, based on your medical condition, as *medically necessary*, we may take less than 72-hours to decide if we will approve benefits.) We will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.
- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your *physician*, within 24-hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 24-hours, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 24-hours. In either event, we will tell you and your *physician* that there is a problem – always in writing by facsimile and, when appropriate, by telephone to your *physician* and in writing by mail to you.
- As soon as we can, based on your medical condition, as *medically necessary*, but, not more than 48-hours after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to the *physician* and by mail to you.

If the request is not for urgently needed *drugs*, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as *medically necessary*, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your *physician* what we have decided in writing - by fax to your *physician*, and by mail, to you.

- If more information is needed to make a decision, we will tell your *physician* in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 5-business days, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your *physician* that there is a problem in writing by facsimile, and when appropriate, by telephone to your *physician*, and in writing to you by mail.
- As soon as we can, based on your medical condition, as *medically necessary*, within 5-business days after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.

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

If you have any questions regarding whether a *drug* is on our *prescription drug formulary*, or requires prior authorization, please call you at 1-800-700-2541.

If we deny a request for prior authorization of a *drug*, you or your prescribing *physician* may appeal our decision by calling us at 1-800-700-2541. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

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 our 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 us 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 a licensed retail *pharmacy*, through our mail service program or through our specialty pharmacy program.
5. **If it is an approved *compound medication*, be dispensed by a *participating pharmacy*.** Call 1-800-700-2541 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.bluecrossca.com.) **Some *compound medications* must be approved before you can get them (See PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.**
6. **If it is a *specialty pharmacy drug*, be obtained by using the specialty pharmacy program.** See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY PHARMACY for how to get your *drugs* by using the specialty pharmacy program. **You will have to pay the full cost of any *specialty pharmacy drugs* you get from a retail *pharmacy* that you should have obtained from the specialty pharmacy program.**

Exceptions to specialty pharmacy program. This requirement does not apply to:

- a. The first two months supply of a *specialty pharmacy drug* which is available through a *participating pharmacy*;
- b. *Drugs*, which due to medical necessity, must be obtained immediately; or

- c. 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 pharmacy program.

If you believe that you should not be required to get your medication through the specialty pharmacy 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 us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at 1-800-700-2541 to request one. You can also get the form on-line at www.bluecrossca.com. If we have 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 pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a *specialty pharmacy drug* subject to the specialty pharmacy program. If you are out of a *specialty pharmacy drug* which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy 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 shown under SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*.

If you order your *specialty pharmacy drug* through the specialty pharmacy program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the *drug* immediately, we will authorize an override of the specialty pharmacy 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 pharmacy program will coordinate the exception and you will not be required to make an additional co-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, sanitarium, 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 pharmacy 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 for retail *pharmacies*. If the *drugs* are obtained through the mail service program, the co-payment will remain the same as for any other *prescription drug*.

9. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.
10. For the mail service program, the *prescription* must not exceed a 90-day supply.
11. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.
12. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

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 copayment for *brand name drugs*.
2. Insulin.
3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.
4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year* and are subject to the copayment for *brand name drugs*.

5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or *family member*. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.
7. Diabetic supplies (i.e. test strips and lancets).
8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.
9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this *prescription drug* benefit, these items are covered under the "Blood" and "Immunizations" 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," 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" 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.
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" provision (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, sanitarium, 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, sanitarium, 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, sanitarium, 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 diaphragms 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", "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” 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 we determine that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section “Independent Medical Review of Denials of Experimental or Investigative Treatment” (see Table of Contents) for how to ask for a review of your *drug* denial.)
13. Any expense incurred for a *drug* or medication in excess of: (a) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies*; or (b) the *prescription drug negotiated rate*, for *drugs* dispensed by *participating pharmacies* or through the mail service program.
14. *Drugs* which have not been approved for general use by the State of California Department of Health 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. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.
20. 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.
21. 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 "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.
22. 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.
23. *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.
24. *Compound medications* obtained from other than a *participating pharmacy*. **You will have to pay the full cost of the *compound medications* you get from a *non-participating pharmacy*.**
25. *Specialty pharmacy drugs* that must be obtained from the specialty pharmacy 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 pharmacy drugs* you get from a retail *pharmacy* that you should have gotten from the specialty pharmacy program.**

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

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

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

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

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

EFFECT ON BENEFITS

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

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

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

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

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

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

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
 - b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
 5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
 6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Family Members. If you are a *full-time employee* or a *family member* of a *full-time employee*, and entitled to Medicare, you will receive the full benefits of this *plan*, except as listed below:

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

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

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

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

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

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

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

UTILIZATION REVIEW PROGRAM

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

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

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

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 we have 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 us 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*, *severe mental disorders*, and substance abuse.
- Organ and tissue transplants.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Bariatric surgical services performed at a *Centers of Expertise* facility.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your

identification card to find out if an imaging procedure requires pre-service review.

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, severe mental disorders*, and substance abuse.
- Organ and tissue transplants.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Bariatric surgical services performed at a *Centers of Expertise* facility.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an emergency admission to the hospital.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions.
 - *Facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders*, and substance abuse.
 - Organ and tissue transplants as follows:
 - a. For kidney, 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 liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement 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 Expertise (COE)* facility.
 - A specified number of additional visits for physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Physical Therapy, Physical Medicine or Occupational Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

- 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 *Centers of Expertise (COE)* facility.
- Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

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

2. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of

the services were not *medically necessary* and appropriate, benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed.

Pre-service Reviews

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 us 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. We will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, we will, if appropriate, specify a specific length of *stay* for services. For *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders*, and substance abuse we 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 us for concurrent review. For an *emergency* admission or procedure, we 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 we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. We will also determine the medically appropriate setting.
4. If we determine that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your *physician* within two business days following our 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", we may take into account whether or not your condition was severe enough to prevent you from notifying us, or whether or not a member of your family was available to notify us 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 we are 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

We 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, we are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our 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 we do not have the information we need, we will make every attempt to obtain that information from you or your *physician*. If we are unsuccessful, and a delay is anticipated, we will notify you and your *physician* of the delay and what we need to make a decision. We 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 our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,
 - reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.
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. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

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

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

PERSONAL CASE MANAGEMENT

The personal case management program enables us to authorize 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, we have the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive personal case management, nor do we have an obligation to provide it; we provide these services at our sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

Members may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or Blue Cross claims reports. The *member* or the *member's* family may also call Blue Cross.

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. We anticipate that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. Our 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 our recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If we determine 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.

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

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward any Lifetime Maximum.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member*, which alternatives may be offered and the terms of the offer.
3. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *member*.
4. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member*.

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

QUALITY ASSURANCE

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you are (a) an active, regularly assigned, full-time staff employee who works at least 30 hours a week in the conduct of the business of the *group*, (b) an active, regularly assigned staff employee in an approved "9 to 12 month" position who works at least 30 hours a week in the conduct of the business of the group, (c) an active, regularly assigned, full-time faculty member employed under a regular (non-adjunct) faculty contract, serving at least a half-time appointment (.5 fte) during each academic year or (d) a *retired employee* who is between the age of 55 and 65 on the date of retirement, is retired from active full-time employment, and was covered under a *group* sponsored plan immediately prior to retirement.
2. **Family Members.** The following persons are eligible to enroll as *family members*: (a) Either the *subscriber's spouse* or *domestic partner*; and (b) An unmarried *child*.

Definition of Family Member

1. **Spouse** is the *subscriber's* spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.
2. **Domestic partner** is the *subscriber's* domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.
3. **Child** is the *subscriber's*, *spouse's* or *domestic partner's* unmarried natural child, stepchild, legally adopted child, or a child for whom the *subscriber*, *spouse* or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:
 - a. The child depends on the *subscriber*, *spouse* or *domestic partner* for financial support or the *subscriber*, *spouse* or *domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
 - b. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 12 or more credits) in a properly accredited two year community college, four year college or university, or an accredited post-high school trade or technical school. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month coinciding with or following the date of eligibility.
 - c. The unmarried child is 19 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 *subscriber*, *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. We must receive the certification, at no expense to us, within 31-days of the date the child first becomes eligible under this *plan*. After a period of two years has passed from the initial certification to us, we may request proof of continuing dependency and that a physical or mental condition

still exists, but, not more often than once each year. This exception will last until the child is no longer chiefly dependent on the *subscriber*, *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.

- d. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, *spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *subscriber's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

- e. A child for whom the *subscriber* or *spouse* is legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.
- f. The term "child" does not include any person who is: (i) covered as a *subscriber*, or (ii) in active service in the armed forces.
- g. If both parents are covered as *subscribers*, their children may be covered as the *family members* of either, but not of both.

Note. *Family member* includes a previously enrolled *spouse* or *child* of a retired employee over age 65 provided the *spouse* is under age 65.

ELIGIBILITY DATE

1. For *subscribers*, you become eligible for coverage on the first day of the month coinciding with or following your date of hire. (This is your "waiting" period.)
2. For *family members*, you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *family member* definition.

Exceptions to the Waiting Period

1. If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible on the first day of the month coinciding with or following the date you return.
2. If you were covered under the *prior plan*, the time you spent under the *prior plan* will be used to satisfy, or partially satisfy, your waiting period under this *plan*.

ENROLLMENT

To enroll as a *subscriber*, or to enroll *family members*, the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 45 days from your initial eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 45 days* after your initial eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month coinciding with or following the date the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement*, provided the enrollment application is on time and in order.

*Note. 30 days for mid-year changes.

Exception. For a newly married couple, the *spouse* is eligible on the date of marriage. For a new domestic partnership, the *domestic partner* is eligible on the date of the domestic partnership.

2. **Late Enrollment for Family Members.** If you file an enrollment application or membership change form for *family members* with the *group* more than 30 days after their eligibility date, they must wait until the *group's* next Open Enrollment Period to enroll.

3. **Disenrollment:** If *family members* are disenrolled from coverage under the *plan*, the family member will be eligible to reapply for coverage as set forth in the “Enrollment” provision above, during the *group’s* next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

NOTE: You may enroll your *family members* earlier than the *group’s* next Open Enrollment Period if they meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

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

In both cases, coverage will be in effect for 30 days. For coverage to continue beyond this 30-day period, the *subscriber* must enroll the *child* within the 30-day period by submitting a membership change form to the *group*. We must then receive the form from the *group* within 90 days.

Special Enrollment Periods

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

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA or CalCOBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
 - b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under

this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the *group's* next open enrollment period to do so.

- c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA or CalCOBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no share-of-cost Medi-Cal coverage.
 - d. You properly file an application with the *group* within 30 days from the date on which you lose coverage.
2. A court has ordered coverage be provided for a *spouse, domestic partner* or dependent *child* under your employee health plan and an application is filed within 30 days from the date the court order is issued.
 3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 30 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *group's* next open enrollment period.
 4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
 - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 30 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless

they qualify under another of these circumstances listed above. Application must be made within 30 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 30 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

OPEN ENROLLMENT PERIOD

The *group* has an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *subscriber's plan*.

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

HOW COVERAGE ENDS

Your coverage ends without notice from us as provided below:

1. If the *agreement* terminates, your coverage ends at the same time. This *agreement* may be canceled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If this *agreement* is amended to delete coverage for *family members*, a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when *subscriber's* coverage ends.
4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.
7. Coverage ends if you are a *retiree* who reaches age 65. However, coverage may continue for *family members* until:
 - a. The *spouse* reaches age 65, unless divorced or annulled prior to that date. In the event of the retiree's death, coverage may be continued until the attainment of age 65 or remarriage.
 - b. The child ceases to meet the definition of child and is no longer eligible under the *plan*.
 - c. The spouse and child become covered under another employer plan.

Exceptions to item 6:

- a. **Leave of Absence.** If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue (i) for up to 12 months during a medical or sabbatical leave of absence; or (ii) for up to one month during a personal leave of absence. Such leave of absence must be approved by the *group*.
- b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child has a physical or mental condition that makes them incapable of obtaining self-sustaining employment. We must receive the certification, at no expense to us, within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. 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 a marriage or domestic partnership terminates, the *subscriber* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the “Eligible Status” provisions. If Blue Cross suffers a loss because of the *subscriber* failing to notify the *group* of the termination of their marriage or domestic partnership, Blue Cross may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *group* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber’s* marriage or domestic partnership, 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 COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, COVERAGE FOR SURVIVING FAMILY MEMBERS, EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.

Unfair Termination of Coverage. Your coverage may not be terminated because of your health status or requirements for health care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the Director of the Department of Managed Health Care.

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *agreement* as either a *subscriber* or *family member*; and (b) a *child* who is born to or placed for adoption with the *subscriber* during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. For Subscribers and Family Members:

- a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or
- b. A reduction in the *subscriber's* work hours.

2. For Retired Employees and their Family Members. Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:

- a. The *agreement* expressly includes coverage for retirees; and
- b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

3. For Family Members:

- a. The death of the *subscriber*;
- b. The *spouse's* divorce or legal separation from the *subscriber*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *agreement*; or
- d. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *agreement* if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *group* or its administrator (we are not the administrator) will notify either the *subscriber* or *family member* of the right to continue coverage under COBRA, as provided below:

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

If you choose to continue coverage you must notify the *group* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *members* within a family, or only for selected *members*.

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

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *group* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "subscription charge", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the subscription charge each month from the *group* in order to maintain the coverage in force.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*;
2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the family rate; and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

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

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

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

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

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

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

3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *agreement* terminates;
5. The end of the period for which subscription charges are last paid;
6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *member* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*. Additional note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

Subject to the *agreement* remaining in effect, a retired *subscriber* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *subscriber's* death. But coverage could terminate prior to such time for either the *subscriber* or *family member* in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this *plan* ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The *group* will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

If continuation coverage ends due to items 2 or 7 above, a surviving spouse and *family members* are eligible for the coverage specified in this *plan* under COVERAGE FOR SURVIVING FAMILY MEMBERS.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

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

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

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

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event*;
3. The date the *agreement* terminates;
4. The end of the period for which subscription charges are last paid;
5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

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

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

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

CALCOBRA CONTINUATION OF COVERAGE

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

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or
2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

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

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, we will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify us in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later. If you don't give us written notification within this time period you will not be able to continue your coverage.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

Additional Family Members. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "subscription charge"). This cost will be:

1. 110% of the applicable *group* rate if your coverage under federal COBRA ended after 18 months; or
2. 150% of the applicable *group* rate if your coverage under federal COBRA ended after 29 months.

You must make payment to us within the timeframes specified below. We must receive payment of your subscription charge each month to maintain your coverage in force.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first-class mail or other reliable means of delivery, in an amount sufficient to pay any required subscription charges and subscription charges due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding subscription charges are due on the first day of each following month.

If subscription charges are not received when due, your coverage will be cancelled. We will cancel your coverage only upon sending you written notice of cancellation at least 15 days prior to cancelling your coverage. If you make payment in full within 15 days after we issue this notice of cancellation, your coverage will not be cancelled. If you do not make the required payment in full within this 15 day period, your coverage will be cancelled as of 12:00 midnight on the fifteenth day after the date on which the notice of cancellation is sent and will not be reinstated. Any payment we receive more than 15 days after we issue the notice of cancellation will be refunded to you within 20 business days.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any subscription charge due date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the *prior plan*, your coverage may continue under this *plan* for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and subscription charge payment requirements of this *plan* within 30 days of receiving notice that your continuation coverage under the *prior plan* will end.

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

For *family members* properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *agreement* terminates;
3. The date the *group* no longer provides coverage to the class of *members* to which you belong;

4. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);
5. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
6. The date you become entitled to Medicare; or
7. The date you become covered under a federal COBRA continuation.

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

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

If your CalCOBRA continuation under this *plan* ends in accordance with items 1, 2, or 3, you may be eligible for HIPAA coverage or medical conversion coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of subscription charges as stated in the *agreement*, coverage under this *plan* may be continued for the *subscriber*, the *subscriber's spouse*, and the *subscriber's former spouse* (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former *spouse*" means: (a) an individual who is divorced from the *subscriber*; or (b) an individual who was married to the *subscriber* at the time of the *subscriber's* death.

Requirements. The *subscriber* and *spouse* may continue coverage under this *plan* if:

1. The *subscriber*, or the *subscriber* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;
2. The *subscriber* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *subscriber* has worked for the employer for at least the prior five years; and
4. The *subscriber* is at least 60 years old on the date employment with the employer ended.

The former *spouse* may continue coverage under this *plan* in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding section.

Notice and Election. The employer will notify the *subscriber* or *spouse* and the former *spouse* of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the *subscriber* and *spouse*, this continuation may be chosen for both, for the *subscriber* only, or for the *spouse* only. The former *spouse* may elect this continuation for himself or herself only.

To elect this continuation, you must notify us in writing within 30 days prior to the date continuation coverage under COBRA or CalCOBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. You must remit the initial subscription charge to us within 45 days after you elect this continuation.

Cost of Coverage. You are required to pay the entire cost of this continuation coverage. You must remit this cost to us each month during the continuation period. We must receive payment of the subscription charge each month in order to continue the coverage in force. The rate for continuation coverage under this section shall be 213% of the applicable *group* rate. For the purpose of determining subscription charges payable, the *spouse* or former *spouse* continuing coverage alone will be considered to be a *subscriber*.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding subscription charges are due on the first day of each following month (the Subscription Charge Due Date).

Grace Period. For every Subscription Charge Due Date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any Subscription Charge Due Date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying accurate, up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide. We can hold you responsible for any loss or expense we incur because of your failure to do so.

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

1. The end of the period for which subscription charges are last paid;
2. The date the *agreement* terminates;
3. The date, following the election of Senior COBRA, the *subscriber*, *spouse*, or former *spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the *subscriber*, *spouse*, or former *spouse* first becomes entitled to Medicare;
5. The date the *subscriber*, *spouse*, or former *spouse* reaches age 65; or
6. For the *spouse* or former *spouse*, five years from the date the *spouse's* or former *spouse's* COBRA or CalCOBRA continuation coverage ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage. If your continuation under this *plan* ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

COVERAGE FOR SURVIVING FAMILY MEMBERS

If the *subscriber* dies while covered under this *plan*, coverage continues for an enrolled *spouse* or *child* until one of the following occurs:

1. The surviving *spouse* remarries;
2. The surviving *spouse* reaches age 65;
3. The surviving *spouse* and *child* become covered under another employer plan;
4. Subscription charges are not paid to us on the *member's* behalf;
5. The *group* cancels coverage for the class of *subscribers* to which the *members* belong;
6. The *agreement* between the *group* and us terminates; or
7. The *child* no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS.

Note: The cost of continuing coverage under this provision will be paid by the group for the first twelve months. Thereafter, the *spouse* or *child* will be responsible for payment of the subscription charges. The cost of continuing coverage may be more than the cost of coverage the *group* provides to its employees or their *family members*.

EXTENSION OF BENEFITS

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

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or

skilled nursing facility, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.

2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
 - a. You are no longer totally disabled.
 - b. The maximum benefits available to you under this *plan* are paid.
 - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
 - d. A period of up to 12 months has passed since your extension began.

HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this *plan* ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your employer's *plan*.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group *plan* ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.

2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program including Senior COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us and make the first subscription charge payment within 63 days of the date your coverage under the employer's *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 *agreement* between the *group* and us terminates and is replaced by another group plan within 15 days.
2. You are not eligible if your coverage under this *plan* ends because subscription charges are not paid when due because you (or the *subscriber* who enrolled you as a dependent) 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.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA 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.

When coverage under your employer's group *plan* ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

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. Our 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 our agents nor are we, or any of our employees, an employee or agent of any *hospital*, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits provided under 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 we are 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, we 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 us.

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, we 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 Blue Cross of California. If you have any questions or complaints about the BlueCard Program, please call us at 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 *agreement*, both the *agreement* and your coverage under the *agreement* 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 *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

Protection of Coverage. Blue Cross does not have the right to cancel your coverage under this *plan* while:

1. This *plan* is in effect;
2. You are eligible; and
3. Your subscription charges are paid according to the terms of the *agreement*.

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 us, 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.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, Blue Cross refunds the unearned part of the subscription charge paid for you. A written request for that refund and satisfactory proof of the need for care must be sent to Blue Cross within 31 days. This payment fulfills the obligation of Blue Cross under this *plan*.

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

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

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

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to Blue Cross within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Blue Cross is not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. We will pay the benefits of this *plan* directly to *contracting hospitals, participating providers, COE* and medical transportation providers. If you or one of your *family members* receives services from *non-contracting hospitals* or *non-participating providers*, payment will be made directly to the *subscriber* and you will be responsible for payment to the provider. Any assignment of benefits, even if assignment includes the providers right to receive payment, is void unless an *authorized referral* has been approved by Blue Cross. We will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members*. We will continue such direct payment until the emergency care results in stabilization. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

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

Plan Administrator - COBRA and ERISA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the *group* or to a person or entity, other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The *group* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, *members* will not be required to pay any *participating provider* or *other health care provider* any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. *Members* may be liable, however, to pay *non-participating providers* any amounts not paid to them by us.

Renewal Provisions. Your employer's health plan *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Confidentiality and Release of Medical Information. We will use reasonable efforts, and take the same care to preserve the confidentiality of the *member's* medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the *member*. Medical information may be released only with the written consent of the *member* or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. *Members* may access their own medical records.

We may release your medical information to professional peer review organizations and to the *group* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *group* to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

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

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Blue Cross 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 with Blue Cross.
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 with Blue Cross.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Blue Cross.

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

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

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

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with Blue Cross prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Blue Cross prior to

termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

Blue Cross will provide such benefits for the completion of covered services by a terminated provider 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 Blue Cross 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 we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the 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 the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider 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, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

BINDING ARBITRATION

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

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

The *member* and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California**

law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.

The *member* and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the *member* waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross 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 initiated by the *member* making written demand on Blue Cross. 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 agreement of the *member* and Blue Cross, or by order of the court, if the *member* and Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Blue Cross will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

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

Agreement is the Group Benefit Agreement issued by Blue Cross to the *group*.

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 25-mile radius of your residence;
2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*, and
3. The referral has been authorized by us 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 *COE*.

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

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

Blue Cross of California (Blue Cross) is a health care service plan, regulated by the California Department of Managed Health Care.

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

Centers of Expertise (COE) are health care providers which have a Centers of Expertise Agreement in effect with us at the time services are
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rendered. *COE* transplant facilities agree to accept the *COE negotiated rate* as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a *COE*. A provider's participation in the Prudent Buyer Plan network or other agreement with us is not a substitute for a Centers of Expertise Agreement.

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

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 an NDC number.

All claims for reimbursement for Compound Medications must be submitted electronically (by the *pharmacy*) and will be paid at the *prescription drug negotiated rate*. Compound Medications may be limited to distribution at designated *pharmacies*.

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

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

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

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 prescribed drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public. For the purposes of this *plan*, insulin will be considered a prescription drug.

Drug limited fee schedule represents the maximum amounts we will allow as *prescription drug covered expense* for *prescriptions* filled at *non-participating pharmacies*. These amounts are the lesser of billed charges or the *average wholesale price*.

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *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 us.

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, severe mental disorders, or substance abuse*.

Family member meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

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

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

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*.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is PEPPERDINE UNIVERSITY.

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, severe mental disorder, or substance abuse*, "hospital" also includes *psychiatric health facilities*.

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

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

Maximum allowable charge is:

1. **For providers, other than *hospitals***, is a charge which will not exceed 130% of the amount that we would have allowed a *participating provider* for the same services; and
2. **For *hospitals***, a charge we consider not be to excessive based on the circumstances of the care provided, including: (a) the level of skill or experience involved; (b) the prevailing or common cost of similar services or supplies; and (c) any other factors which determine value.

Medically necessary procedures, supplies equipment or services are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;

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

Member is the *subscriber* or *family member*.

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

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

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. 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-participating pharmacy is a *pharmacy* which does not have a Participating Pharmacy Agreement in effect with us 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 us 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 us 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. Many

participating pharmacies display a "Rx" decal with our logo in their window so that you can easily identify them.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with us 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.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:
 - a. A dentist (D.D.S. or D.M.D.)
 - b. An optometrist (O.D.)
 - c. A dispensing optician
 - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. A licensed clinical psychologist
 - f. A chiropractor (D.C.)
 - g. An acupuncturist (A.C.)
 - h. A clinical social worker (L.C.S.W.)
 - i. A marriage and family therapist (M.F.T.)

- j. A physical therapist (P.T. or R.P.T.)*
- k. A speech pathologist*
- l. An audiologist*
- m. An occupational therapist (O.T.R.)*
- n. A respiratory care practitioner (R.C.P.)*
- o. A *psychiatric mental health nurse* (R.N.)*
- p. A nurse midwife**
- q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

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

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

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the *agreement* issued to the *group* by Blue Cross. (If any changes are made to the plan, an amendment or a revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change.) (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Pre-existing condition means an illness, injury or condition which existed during the six-month period immediately prior to either (a) your *effective date* or (b) the first day of any waiting period required by the *group*, whichever is earlier. A condition is considered to have existed when you: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.

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 maximum amounts described in items 1 and 2 below. Expense is incurred on the date you receive the service or supply.

Prescription drug covered expense does not include any expense in excess of: (1) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies*; or (2) the *prescription drug negotiated rate*, for *drugs* dispensed by *participating pharmacies* or by the mail service program.

Prescription drug formulary (formulary) is a list which we have 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.

Prescription drug negotiated rate is the rate that we have negotiated with *participating pharmacies* under a Participating Pharmacy Agreement for *prescription drug covered expense*. *Participating pharmacies* have agreed to charge *members* no more than the prescription drug negotiated rate. It is also the rate which Blue Cross of California Prescription Drug Program - Mail Service accepts as payment in full for mail service *prescription drugs*.

Prior plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. A *member* is considered covered under the prior plan if that *member*: (1) was 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 health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

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

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

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

Retired employee is a former *full-time employee* who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

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

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

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

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

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare. For the purpose of care provided for the treatment of *mental or nervous disorders, severe mental disorders*, or substance abuse, the term "skilled nursing facility" includes *residential treatment center*.

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

Specialty pharmacy 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: HOW COVERAGE BEGINS.

Stay is an inpatient confinement of a *member* which begins when the *member* is admitted to a facility and ends when the *member* is discharged from that facility.

Subscriber is the person who, by meeting the *plan's* eligibility requirements for subscribers, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Totally disabled family members are *family members* who are unable to perform all activities usual for persons of that age.

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

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

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

We (us, our) refers to Blue Cross of California (Blue Cross).

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

You (your) refers to the *subscriber* and *family members* who are enrolled for benefits under this *plan*.

GRIEVANCE PROCEDURES

If you have a question about your eligibility, your benefits under this *plan*, or concerning a claim, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card). Our customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the customer service representative. You may complete and return the form to us, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Blue Cross of California website at www.bluecrossca.com. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. After we have reviewed your grievance, we will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of

life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days, you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care for review.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be binding arbitration (see BINDING ARBITRATION).

Questions about your prescription drug coverage. If you have outpatient *prescription drug* coverage and you have questions or concerns, you may call the Pharmacy Customer Service number listed on your ID card. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:

- ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
- ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
 - ◆ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
 - ◆ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
 - a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
 - b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline, and MEDLARS database Health Services Technology Assessment Research;
 - c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 - d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
 - e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

- f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must request this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your *plan* that has been denied, modified, or delayed by us, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any

grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:
 - (a) Your provider has recommended a health care service as *medically necessary*,
 - (b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
 - (c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not *medically necessary*; and
3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is *medically necessary*. You will receive a copy of the assessment made in your case. If the IMR determines the service is *medically necessary*, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to request an application form, please call us at the customer service telephone number listed on your ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site (**<http://www.hmohelp.ca.gov>**) has complaint forms, IMR applications forms and instructions online.

FOR YOUR INFORMATION

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Blue Cross of California web site at www.bluecrossca.com. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

SUMMARY PLAN DESCRIPTION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) – It is not a part of your Evidence of Coverage and Disclosure (Evidence of Coverage) Form. But, this document together with the attached Evidence of Coverage form, issued by Blue Cross of California, constitutes the Summary Plan Description required by ERISA.

1. **Plan Name.** The designated name of the Plan is Pepperdine University Health and Welfare Plan.
2. **Plan Sponsor.** The name and address of the entity which established and maintains the Plan is:

Pepperdine University
24255 Pacific Coast Highway
Malibu, California 90263

(310) 506-4397
3. **Plan Numbers:**

The Employer's Identification Number (EIN) is 95-1644037.

The Plan Number is 501.
4. **Type of Plan.** The Plan is an employee welfare benefit plan providing group medical benefits.
5. **Source of Plan Contributions.** The contributions necessary to finance the Plan are provided by the employer and the employee. However, any contributions necessary to cover a retiree and/or his dependents are paid entirely by the retiree. Any required employee contributions under this plan are subject to the Pre-Tax Premium Cafeteria Plan of Pepperdine University.
6. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on September 1 and ending on the following August 31.

7. **Type of Administration/Funding.** Benefits are furnished under a health care plan purchased by the Plan Sponsor and provided by Blue Cross of California (Blue Cross) under which Blue Cross is financially responsible for the payment of benefits.

Blue Cross' address is:

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367

8. **Plan Administrator.** The name, address and telephone number of the Plan Administrator is:

Pepperdine University
24255 Pacific Coast Highway
Malibu, California 90263
(310) 506-4397

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

Vice President and General Counsel
Pepperdine University
24255 Pacific Coast Highway
Malibu, California 90263
(310) 506-4607

Service of legal process may also be served on the Plan Administrator, Pepperdine University.

10. **Description of Benefits.** The Evidence of Coverage pages set forth the benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is provided under the Prudent Buyer Exclusive Plan. An explanation of the benefits, copays, benefit maximums, limitations and exclusions and the extent to which preventive care is covered, may be found in the sections entitled TYPES OF PROVIDERS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS (including the subsections HOW COVERED EXPENSE IS DETERMINED, DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, and MEDICAL CARE THAT IS NOT COVERED), PRE-EXISTING CONDITION EXCLUSION, REIMBURSEMENT FOR ACTS OF THIRD PARTIES, COORDINATION OF BENEFITS, BENEFITS FOR MEDICAL ELIGIBLE MEMBERS, MEDICAL MANAGEMENT PROGRAMS (including the subsections UTILIZATION REVIEW PROGRAM, AUTHORIZATION PROGRAM, THE MEDICAL NECESSITY REVIEW PROCESS, PERSONAL CASE MANAGEMENT, DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS,

and QUALITY ASSURANCE), GENERAL PROVISIONS, EXTENSION OF BENEFITS, BINDING ARBITRATION, DEFINITIONS and GRIEVANCE PROCEDURES. Information about prescription drug benefits, copays, benefit maximums, limitations and exclusions, including what drugs are covered under the Prudent Buyer Exclusive Plan, and how it is decided what drugs the plan will cover, is provided in the section YOUR PRESCRIPTION DRUG BENEFITS (including the subsections PRESCRIPTION DRUG COVERED EXPENSE, PRESCRIPTION DRUG CO-PAYMENTS, PRESCRIPTION DRUG UTILIZATION REVIEW, PREFERRED DRUG PROGRAM, PRESCRIPTION DRUG CONDITIONS OF SERVICE, PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED and PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED).

If your health care plan includes coverage for pregnancy and maternity care, Federal law prohibits the restriction of benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery or 96 hours following a cesarean section. A health care provider also may not be required to obtain authorization for prescribing a length of stay for childbirth that does not exceed these time periods.

Statement of Rights Under the Women's Cancer Rights Act of 1998

Did you know that your plan, as required by the Women's Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema)? Call your Plan Administrator (see item 8 above) for more information.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

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

- 11. Eligibility for Participation.** The eligibility requirements for participation under the Prudent Buyer Exclusive Plan are set forth in the Evidence of Coverage in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.

12. **Summary Plan Modification Date:** Amended through September 1, 2006.

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

- Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.
- Benefits may be denied or suspended if statements a Plan participant has made in connection with obtaining coverage were false.
- Information concerning situations under which benefits may be reduced or denied may also be found in the sections entitled TYPES OF PROVIDERS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS (including the subsections HOW COVERED EXPENSE IS DETERMINED, DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, and MEDICAL CARE THAT IS NOT COVERED), PRE-EXISTING CONDITION EXCLUSION, REIMBURSEMENT FOR ACTS OF THIRD PARTIES, COORDINATION OF BENEFITS, BENEFITS FOR MEDICAL ELIGIBLE MEMBERS, MEDICAL MANAGEMENT PROGRAMS (including the subsections UTILIZATION REVIEW PROGRAM, AUTHORIZATION PROGRAM, THE MEDICAL NECESSITY REVIEW PROCESS, PERSONAL CASE MANAGEMENT, DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS, and QUALITY ASSURANCE), GENERAL PROVISIONS, EXTENSION OF BENEFITS, BINDING ARBITRATION, DEFINITIONS and GRIEVANCE PROCEDURES. Information about prescription drug benefits, copays, benefit maximums, limitations and exclusions, including what drugs are covered under the Prudent Buyer Exclusive Plan, and how it is decided what drugs the plan will cover, is provided in the section YOUR PRESCRIPTION DRUG BENEFITS (including the subsections PRESCRIPTION DRUG COVERED EXPENSE, PRESCRIPTION DRUG CO-PAYMENTS, PRESCRIPTION DRUG UTILIZATION REVIEW, PREFERRED DRUG PROGRAM, PRESCRIPTION DRUG CONDITIONS OF SERVICE, PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED and PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED).

14. **Claims Procedures.** The Evidence of Coverage Form contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Blue Cross. In addition to this information, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below.

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

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

Non-Urgent Care Pre-Service (when care has not yet been received). Blue Cross must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they get it and tell you what information is missing. You

have 45-days to provide them with the information they need to process your request for benefits. The time period during which Blue Cross is waiting for receipt of the necessary information is not counted toward the time frame in which Blue Cross must make the benefit determination.

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

Concurrent Care Decisions:

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

- **Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
 - You must make a request to Blue Cross for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.
 - If Blue Cross receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If Blue Cross denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). Blue Cross must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim to

them, they must notify you, within 30-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which Blue Cross is waiting for receipt of the necessary information is not counted toward the time frame in which Blue Cross must make the benefit determination.

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

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

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

You may have representation throughout the appeal and review procedure.

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

15. **Amendment and Termination of the Plan.** Pepperdine University (Plan Administrator) reserves the right to change, suspend, amend or end the benefits program, and the terms on which benefits, if any, will be available to its employees. The Vice President for Finance and Administration of Pepperdine University is authorized to amend or modify, in a manner consistent with the terms of the Group Benefit Agreement, or terminate the benefits program at any time and from time to time. Any such amendment, modification or termination will be made by written amendment executed by the Vice President for Finance and Administration of the University.

PLEASE NOTE: Please do not interpret any statement in this booklet to mean that your participation in Pepperdine University's benefits program is a guarantee of continued employment or is intended to be an employment contract of any form.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report; the Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you

request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have

sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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



PRUDENT BUYER EXCLUSIVE AMENDMENT

issued by

ANTHEM BLUE CROSS

to

PEPPERDINE UNIVERSITY

Anthem Blue Cross ("Anthem") agrees to modify your Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form by this amendment. All other provisions of the Evidence of Coverage Form which are not inconsistent with this amendment remain in effect. Officers of Anthem have approved this amendment to become effective September 1, 2008.

The name of the company providing your benefits has changed.

1. Wherever "Blue Cross of California," appears it is replaced in each instance by "Anthem Blue Cross;"
2. Wherever "Blue Cross," appears it is replaced in each instance by "Anthem."



PRUDENT BUYER EXCLUSIVE PLAN AMENDMENT

issued by

ANTHEM BLUE CROSS

to

PEPPERDINE UNIVERSITY

Anthem Blue Cross ("Anthem") agrees to modify your Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form by this amendment. All other provisions of the Evidence of Coverage Form which are not inconsistent with this amendment remain in effect. Officers of Anthem have approved this amendment to become effective September 1, 2009.

The following changes are made to **MEDICAL BENEFIT MAXIMUMS** in the **SUMMARY OF BENEFITS: MEDICAL BENEFITS** section:

The **Mental or Nervous Disorders** provision is deleted and replaced by:

Mental or Nervous Disorders

- For covered outpatient *physician's* services**20 visits**
per calendar year
- For covered *facility-based care*.....**30 days**
per calendar year
- For covered inpatient *physician's* services**30 visits**
per calendar year

The *calendar year* maximum *plan* payment amount applicable to the **Physical Exam (Members Age 7 and Over)** benefit is deleted and of no further effect.

The following provisions are added at the end of the **SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS** section:

Mandatory Generic Program

Prescription drugs will always be dispensed by a *pharmacist* as prescribed by your *physician*. Your *physician* may order a *brand name drug* or a *generic drug* for you. You may request your *physician* to prescribe a *brand name drug* for you or you may request the *pharmacist* to give you a *brand name drug* instead of a *generic drug*. Under this *plan*, if a *generic drug* is available, and it is not determined that the *brand name drug* is *medically necessary* for you to have (see PRESCRIPTION DRUG FORMULARY: Prior Authorization below), you will have to pay the co-payment for the *generic drug* plus the difference in cost between the *prescription drug negotiated rate* for the *generic drug* and the *brand name drug*, but, not more than **\$124**.

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective *drugs* including, but, not limited to, *generic drugs*, mail service *drugs*, over-the-counter *drugs* or *preferred drug* products. Such programs may involve reducing or waiving co-payments for

those *generic drugs*, over-the counter *drugs*, or the *preferred drug* products for a limited time. If we initiate such a program, and we determine that you are taking a *drug* for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Half-tab Program

The Half-Tablet Program allows you to pay a reduced co-payment on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the prescription is written by the *physician* to take "½ tablet daily" of those medications on an list approved by us. The WellPoint National Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your *physician*. To obtain a list of the products available on this program call 1-800-700-2541 (or TTY/TTD 1-800-905-9821) or go to our internet website www.anthem.com/ca.

The following changes are made to **MEDICAL CARE THAT IS COVERED** in the section **YOUR MEDICAL BENEFITS**:

The **Mental or Nervous Disorders** provision is deleted and replaced by:

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

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section, services from a *residential treatment center*, and visits to a *day treatment center*. The combined maximum for inpatient *hospital* and *residential treatment center* services and visits to a *day treatment center* will be 30 days during a *year*.
2. *Physician* visits during a covered inpatient *stay* for the treatment *mental or nervous disorders*, up to 30 visits per *year*.
3. *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*. The combined maximum for all outpatient *physician* visits will be 20 visits during a *year*.

If we apply *covered expense* toward the Calendar Year Deductible and do not provide payment, that day or visit is not included in the maximum for that *year*. However, if we pay any portion of your *covered expense* for a day or visit, it will be counted in the maximum.

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

The **Physical Exam (Members Age 7 and Over)** provision is deleted and replaced by:

Physical Exam (Members Age 7 and Over). We will pay, after any applicable co-payment, for the following services when provided for a *member* age 7 or over:

1. A *physician's* services for routine physical examinations. You must pay a **\$15** co-payment for each examination.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

Prostate cancer screenings, cervical cancer screenings including human papillomavirus (HPV) screening, breast cancer screenings, colorectal cancer screenings, and other cancer screenings are not covered under this "Physical Exam" benefit but are covered under the medical care provisions of this *plan* as described under "Adult Preventive Services", "Breast Cancer" and "Other Cancer Screening Tests", subject to the terms and conditions of this *plan* that apply to those benefits.

The **Adult Preventive Services** provision is deleted and replaced by:

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, colorectal cancer screenings, and the

office visit related to those services. The Calendar Year Deductible will not apply to these services.

The **Other Cancer Screening Tests** provision is deleted and replaced by:

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

The following provision is added:

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.

The following applies to the "Prior Authorization," provision in subsection section entitled either "**PREFERRED DRUG PROGRAM,**" or "**PRESCRIPTON DRUG FORMULARY,**" in the section **YOUR PRESCRIPTION DRUG BENEFITS:**

1. The first paragraph of the provision "Prior Authorization," is replaced by the following:

Prior Authorization. Certain *drugs* require written prior authorization of benefits in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the drug originally requested at the applicable co-payment. (If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, and you underwent a prior authorization process under the prior plan which required you to take different drugs, we will not require you to try a *drug* other than the one you are currently taking.) If approved, *drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

2. The following provision is added at the end of the Prior Authorization section:

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

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

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

The following applies to **THE MEDICAL NECESSITY REVIEW PROCESS** provision in the section **UTILIZATION REVIEW PROGRAM**:

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

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

The following changes are made to the section **HOW COVERAGE BEGINS AND ENDS**:

Paragraphs (b) and (c) of the definition of "child" under the **Definition of Family Member** are deleted and replaced by the following:

- b. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school). Any break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.
- c. The unmarried child is 19 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 *subscriber, 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. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We 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 *subscriber, 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.

The **Handicapped Children** exception to the provision **HOW COVERAGE ENDS** is deleted and replaced by the following:

- b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and

(iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

The following is added as an additional exception to the provision
HOW COVERAGE ENDS:

- c. **Full time students taking a medical leave of absence from school:** If a *child* who is 19 years of age or more, enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school), and covered under this *plan* in accordance with the “Eligible Status” provision of this section, the *child* may remain covered under this *plan* for a period not to exceed 12 months or until the date the *child’s* coverage would normally end in accordance with the terms and conditions of this *plan*, whichever comes first, during a medical leave of absence from school. This provision applies if the nature of the *child’s* health condition does not meet the requirements of the “Handicapped Children” provision, above. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a *physician* determines the child's illness, injury, or condition prevented the *child* from attending school, whichever comes first. Any break in the school calendar will not disqualify the *child* from maintaining coverage under this provision. A *physician* must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to us at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to us within 30 days after the date the leave begins.