Benefit Booklet

(Referred to as “Booklet” in the following pages)

Anthem PPO Plan

PPO Network

University of California Student Health Insurance Plan

UC SANTA CRUZ
Students and Dependents

2024-25

Important Numbers

UC Santa Cruz Student Health Services

Insurance Department	**1-831-459-2389**
By Phone/Appointments:	**1-831-459-2500**
By Phone/Appointments:	**1-831-459-2500**
Counseling and psychological services/ incl. After Hours:	**1-831-459-2628**
After Hours Advice Nurse:	**1-831-459-2591**
UC SHIP Member Services Number:	**1-866-940-8306**
Academic Health Plans (AHP):	**1-855-427-3175** ucship@ahpservice.com
LiveHealth Online	**1-888-LiveHealth (1-888-548-3432)**
Anthem Nurseline:	**1-877-351-3457**
Future Moms:	**1-866-664-5404**

Locations

UCSC Student Health Center
1156 High Street
Santa Cruz, CA 95064

UC SHIP website: **myucship.org**

Introduction

Dear Plan Member:

This Benefit Booklet gives you a description of your benefits while you and your eligible Dependents are enrolled under the University of California Student Health Insurance Plan (UC SHIP) (the "Plan") offered by your University. You should read this Benefit Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely. If you have any questions about the benefits shown in this Benefit Booklet, please call your Student Health Services or UC SHIP Member Services at 1-866-940-8306.

The Plan benefits described in this Benefit Booklet are for eligible Members only during the 2024-2025 Plan year. The health care services are subject to the limitations and exclusions, Copayments, Deductible, and Coinsurance rules given in this Benefit Booklet.

Many words used in this Benefit Booklet have special meanings (e.g., Covered Services and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Benefit Booklet you may also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" refer to the Claims Administrator or the Plan. The words "you" and "your" mean the Member, Insured student and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at 1-866-940-8306. Also be sure to check the Claims Administrator's website, www.anthem.com/ca for details on how to locate a Provider, get answers to questions, and access valuable health and wellness tips.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the University of California Student Health Insurance Plan who is responsible for their payment. Anthem Blue Cross Life and Health (the Claims Administrator) provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Your University has agreed to be subject to the terms and conditions of Anthem's provider agreement which may include Pre-service Review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in the State of California. Although Anthem is the Claims Administrator and is licensed in California you will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with UC SHIP on its own behalf and not as the agent of the Association.

Your Right to Appeals

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied:

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

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan’s review procedures and the time limits that apply to them
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the Claims Administrator’s notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator’s may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals (Grievances)

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at 1-866-940-8306 and provide at least the following information:

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

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

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

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

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

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

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

For Out of State Appeals (Grievances)

You have to file Provider Appeals with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). This means Providers must file Appeals with the same plan to which the claim was filed.

Eligibility (Grievances)

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

How Your Appeal will be Decided

When the Claims Administrator considers your appeal, the Claims Administrator's review will not rely upon the initial benefit determination (claim denial). The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

An additional voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for the health care professional who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile, or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the phone number listed on your Identification Card (1-866-940-8306) and provide at least the following information:

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

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

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

You must include your Member Identification number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit

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

The Claims Administrator reserves the right to modify the policies, procedures, and timeframes in this section in accordance with applicable law.

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Periods of Coverage

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Coverage Periods			
Registered Undergraduate and Graduates	9/21/24-1/2/25	1/3/25-3/30/25	3/31/25-9/19/25

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please contact your student health services.

Eligible Status

The Insured Student

To be eligible to enroll, individual must be entitled to participate in the benefit Plan.

Insured Students

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

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

Eligible Non-Registered Students

1. The following class of individuals may enroll voluntarily as Insured students:

   a. All non-registered filing fee status graduate students of the University of California who are completing work under the auspices of the University of California, as determined by the campus, but are not attending classes. Students on filing fee status may purchase Plan coverage for a maximum of one quarter by contacting AHP at 1-855-427-3175 or by email to ucship@ahpservice.com. The student must have been covered by the Plan in the term immediately preceding the term for which the student wants to purchase coverage or, if the student waived Plan enrollment, show proof of involuntary loss of the coverage used to obtain the waiver.

   b. All non-registered students of the University of California, as determined by the campus, who are on planned educational leave or an approved leave of absence status. While in either status, these students may purchase Plan coverage for a maximum of two quarters. The student must have been covered by the Plan in the term immediately preceding the term for which the student wants to purchase coverage or, if the student waived Plan enrollment, show proof of involuntary loss of the coverage used to obtain the waiver. Some university services are available for a fee during the LOA. Students returning from LOA are able to enroll with the continuing students during priority enrollment. These students may enroll by contacting AHP at 1-855-427-3175 or by email to ucship@ahpservice.com.

   c. All former students of the University of California who completed their degree at UC (graduated) during the term immediately preceding the term for which they want to purchase coverage. Provided these individuals were enrolled in the Plan in the preceding term, they may purchase the Plan coverage for a maximum of one quarter. These individuals may enroll by contacting AHP at 1-855-427-3175 or by email to ucship@ahpservice.com.

Dependents

Eligible Dependents

1. The following class of Dependents of Insured students may enroll voluntarily in the Plan:

    - Spouse: Legally married spouse of the Insured student.
    - Domestic Partner: The individual designated as an Insured student's Domestic Partner under one of the following methods: (i) registration of the partnership with the State of California; or (ii) establishment of a same or opposite sex legal union, other than marriage, formed in another jurisdiction that is substantially equivalent to a State of California-registered domestic partnership;
    - Child: The Insured student's child(ren) as follows:
        - Biological child under the age of 26.
        - Stepchild: A stepchild under the age of 26 is a Dependent as of the date the Insured student marries the child's parent.
        - Adopted child under the age of 26, including a child placed with the Insured student or the Insured student's Spouse or Domestic Partner, for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
        - Child of the Insured student's Domestic Partner: A child of the Insured student's Domestic Partner under the age of 26 is a Dependent as of the Effective Date of the domestic partnership.
        - Foster Child: A foster child under the age of 18 is a Dependent from the moment of placement with the Insured student as certified by the agency making the placement. In certain circumstances, the foster child age limit may be extended in accordance with the provision for a non-minor Dependent, as defined in the California Welfare and Institutions Code Section 11400(v).
        - A child for whom the Insured student is legally required to provide health insurance in accordance with an administrative or court order, provided that the child otherwise meets UC SHIP eligibility requirements.
        - Dependent Adult Child: A child who is 26 years of age or older and: (i) was covered under the prior plan, or has six or more months of creditable coverage, (ii) is chiefly dependent on the student, Spouse or Domestic Partner for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A Physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. The University may request proof of these conditions in order to continue coverage. The University must receive the certification, at no expense to the University, within 60 days of the date the student receives the request. The University may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the student, Spouse or Domestic Partner for support and maintenance due to a continuing physical or mental condition. A Dependent adult child is considered chiefly dependent for support and maintenance if he or she qualifies as a Dependent for federal income tax purposes.

          Note: If both student parents are covered as Insured students, their children may be covered as the Dependents of either, but not of both.

2. Students are required to provide proof of Dependent status when enrolling their dependents in the Plan. Proof is required once per year in English or with English translation. The following documents will be accepted:

    - For Spouse, a marriage certificate

- For a Domestic Partner, a Certificate of Registered Domestic Partnership issued by the State of California, or of same or opposite sex legal union other than marriage formed in another jurisdiction.
- For a biological child, a birth certificate showing the student is the parent of the child
- For a stepchild, a birth certificate, and a marriage certificate showing that one of the individuals listed on the birth certificate is married to the student
- For a biological child of a Domestic Partner, a birth certificate showing the Domestic Partner is the parent of the child
- For an adopted or foster child, documentation from the placement agency showing that the student or the Domestic Partner has the legal right to control the child's health care
- For a child covered under a court order, a copy of the document from the court
- International student dependents must provide a copy of their passport.

To obtain coverage for children, the Plan requires you to give AHP a copy of any legal documents awarding guardianship of such child(ren) to you. This must be provided or translated into English.

Types of Coverage

The types of coverage available to the Insured students and eligible Dependents are indicated at the time of enrollment through the Plan Administrator.

When You Can Enroll

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

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

Non-registered students and eligible Dependents who enroll on a voluntary basis must submit an electronic enrollment application for each academic term of coverage. Enrollment applications must be received within 30 days of the start of the coverage period. The coverage will begin on the first day of that period. **Enrollment will not be continued to the next Coverage Period (academic term) unless a new electronic application is received. A reminder of re-enrollment will be provided, but it is the student's responsibility to make sure their coverage continues to next term by contacting AHP.**

To enroll a Dependent, you may either contact AHP Customer Care Unit at 1-855-427-3175 or complete the online enrollment application found on your campus Student Health Center web page. Your dependents must meet all Dependent eligibility criteria established by the Plan Administrator and be one of the following.

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

1. For Spouse, the date of issuance of the marriage certificate.

2. For a Domestic Partner, the date that the Certificate of Registered Domestic Partnership is filed with the State of California, other jurisdiction.
3. For a biological child, the date of birth.
4. For an adopted or foster child, the date of placement with the student or Domestic Partner.
5. For any Dependent, the date of loss of other coverage. An official letter of termination from the insurance carrier must be provided at the time of enrollment in UC SHIP.
6. For a child covered under a court order, the date that the court orders that the child be covered.

Non-registered students and eligible Dependents enroll by contacting AHP at 1-855-427-3175 or emailing ucship@ahpservice.com**.**

Important Note Regarding Newborn Children. If the student is already covered, any child born to the student will be covered under the student's benefits from the moment of birth, provided Anthem Blue Cross is notified of the birth within 31 days. Coverage will be in effect for 31 days under the covered parent's plan without additional cost to the student. If both parents are UC SHIP members, the newborn coverage will be assigned to the mother for the first 31 days.

For continued newborn coverage beyond the 31 days described in the preceding paragraph, the parent must enroll the newborn as a Dependent under UC SHIP within 31 days of the date of birth. The student must contact AHP at 1-855-427-3175 or complete the electronic application on your campus Student Health Center website to enroll the child as a Dependent.

Special Enrollment Periods

If a student or Dependent does not enroll for coverage when they were first eligible, they may be able to join the Plan if they qualify for Special Enrollment. The student or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or Plan Administrator contributions toward coverage were terminated.
- Lost employer contributions towards the cost of the other coverage
- Are now eligible for coverage due to marriage, domestic partnership, birth, adoption, or placement for adoption.
- Non-registered students must have been enrolled the previous term to be eligible for the special enrollment

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender or age.

Statements and Forms

All Members must complete forms or statements that the Plan may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. This does not apply, however, to fraudulent misstatements.

Address or Name Update

See instructions for updating your personal information (name, date of birth, gender, pronouns, or lived name) at the Office of the Registrar—Personal Information FAQs. You may need to complete forms for certain changes. We'll receive your changes within a day or two.

Let Student Health Services know if you need to update your address while covered under the Plan. Please call 831-459-2500 or send an email to insure@ucsc.edu. If you would like to opt to receive communications electronically, log into the Anthem member portal at www.anthem.com/ca, to select email option and receive the information electronically.

How Your Plan Works

IF YOU ARE ENROLLED UNDER THIS PLAN AS A STUDENT AND YOU NEED NON-EMERGENCY OR NON-URGENT MEDICAL CARE, YOU MUST FIRST GO TO OR CONTACT THE STUDENT HEALTH SERVICES FOR TREATMENT DURING THEIR REGULAR HOURS OF OPERATION. THE STUDENT HEALTH SERVICES WILL HELP YOU LOCATE PROVIDERS AND ISSUE REFERRALS TO MEDICAL PROVIDERS WHEN ADDITIONAL CARE OR A SPECIALIST IS NEEDED. COVERED DEPENDENTS MUST SEEK CARE FROM OFF-CAMPUS PROVIDERS AND DO NOT REQUIRE REFERRALS.

Student Health Services (SHS) is the student's medical home. You may choose from among SHS providers for your primary, wellness care, some specialty care, and other services. Your SHS Provider will diagnose and treat most illnesses, coordinate all of your health care and provide a Referral if you need care outside the SHS. With the Referral in hand you choose from Network Providers, or Out-of-Network Providers. *Review the benefits listed in this Benefit Booklet to determine your most cost-effective option.*

Referrals are made at the sole and absolute discretion of the SHS. The Referral does not guarantee payment or coverage, and your Deductible, Copayment or Coinsurance may apply. The services you obtain must be Medically Necessary and a covered benefit under this Plan. Exceptions: students are not required to obtain a SHS referral for Emergency or urgent care, LiveHealth Online, pediatric dental or vision for members under age 19, or services of a pediatrician, obstetrician, or gynecologist.

IF A STUDENT RECEIVES MEDICAL CARE WITHOUT PRIOR REFERRAL FROM THE STUDENT HEALTH SERVICES, THE EXPENSES WILL NOT BE COVERED, EXCEPT FOR THE EXCEPTIONS LISTED ABOVE.

Note: Student Health Services (SHS) on campus does not provide medical, pharmacy, dental and vision services for covered Dependents. Covered Dependents may seek medical services off campus from any health care professional or Facility without the need of referral.

Network Services

Your Plan is a PPO plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If you choose a Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more in out-of-pocket expenses**.**

When you use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. The Claims Administrator has final authority to determine the Medical Necessity of the service. Referrals are required from the Student Health Services to visit a Network Specialist, including behavioral health Providers. **This does not apply to Emergency care, urgent care, LiveHealth Online, pediatric dental or vision for members under age 19, services of a pediatrician, obstetrician, or gynecologist.**

If you receive Covered Services from an Out-of-Network Provider after the Plan failed to provide you with accurate information in our Provider Directory, or after the Plan failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has final authority to decide the Medical Necessity of the service.

Network Providers include various types of "Network Providers" who contract with the Claims Administrator to care for you. These providers are called "Network Providers" because they have agreed to participate in the Claims Administrator's preferred provider organization program (PPO), called the Prudent Buyer Plan. Network Providers have agreed to rates they will accept as reimbursement for Covered Services. The cost of benefits provided under this Plan will generally be lower for Network Providers than for Out-of-Network Providers. Referrals are required from the Student Health Services in order to visit a Network Specialist, including behavioral health Providers. **This does not apply to Emergency care, urgent care, LiveHealth Online, pediatric dental or vision for members under age 19, services of a pediatrician, obstetrician, or gynecologist. The University of California five health systems, including hospitals, and other medical facilities, and affiliated professional providers have agreed to special discounted rates for UC SHIP members.**

Upon receiving the Referral to see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you. You can provide a copy from your Sydney Health Mobile App from the App Store or Google Play or www.anthem.com/ca

For services rendered by Network Providers:

1. You will not be required to file any claims. Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your Network Provider(s) for any non-Covered Services you get or when you have not followed with the terms of this Benefit Booklet.

2. Precertification will be done by the Network Provider. See the "Getting Approval for Benefits" section for further details.

Please refer to the "Claims Payment" section for additional information on Authorized Services.

Note: Payment of Emergency room claims is subject to review by the Claims Administrator. The Claims Administrator makes the final determination regarding whether services were rendered for an Emergency.

Contracting and Non-Contracting Hospitals are another type of service provider. They are different from a Hospital which is a Network Provider. The Claims Administrator has contracted with most hospitals in California to obtain certain advantages for patients covered under the Plan. While only some hospitals are Network Providers, all eligible California hospitals are invited to be Contracting Hospitals and most--over **90%**--accept. **For those which do not (called Non-Contracting Hospitals), there is a significant benefit penalty in your Plan.**

Out-of-Network Services and Benefits

IMPORTANT NOTE: Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. **Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details. The Member is responsible for costs in excess of the Maximum Allowed Amount which includes costs exceeding your Out-of-Pocket Maximum.**

Services which are not obtained from a Network Provider or as part of an Authorized Service will be considered an Out-of-Network service, unless otherwise indicated in this Benefit Booklet. You must obtain a Referral from the Student Health Center to seek treatment from an Out-of-Network provider.

For services rendered by an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount, unless your claim involves a Surprise Billing Claim, and for certain non-Emergency Covered Services that you receive from an Out-of-Network Provider while you are at an In-Network Facility, as described under "Member Cost Share" in the "Claims Payment" section. The Member is responsible for costs in excess of the Maximum Allowed Amount which includes costs exceeding your Out-of-Pocket Maximum;

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments), unless your claim involves a Surprise Billing Claim, and for certain non-Emergency Covered Services that you receive from an Out-of-Network Provider while you are at an In-Network Facility, as described under "Member Cost Share" in the "Claims Payment" section;

3. You will have to pay for services that are not Medically Necessary;

4. You will have to pay non-Covered Services;

5. You may have to file claims; and

6. You must make sure any necessary Precertification is done. Please see the "Obtaining Approval for Benefits" section for further details.

Exceptions to Out-of-Network Services and Benefits:

Your Co-Insurance for Out-of-Network Providers will be the same as for Network Providers for the following services. You may be responsible for charges which exceed the Maximum Allowed Amount.

a. Emergency services provided by other than a Hospital*;*

b. The first 48 hours of Emergency services provided by a *hospital* (the Network Provider Co-Insurance will continue to apply to an Out-of-Network Provider beyond the first 48 hours if you, in the Claims Administrator's judgment, cannot be safely moved);

c. The services of an Out-of-Network Provider when Anthem approves a referral from a Physician who is a Network Provider or from the student health services (see the provision AUTHORIZED SERVICE(S) on page 107).

d. Charges by a type of Physician not represented in the Prudent Buyer Plan network (for example, an audiologist).

e. Clinical Trials; or

f. The services of an anesthesiologist and assistant surgeon who are Out-of-Network Providers when the Hospital where the surgery is to be performed, or Ambulatory Surgery Center, AND the operating Physician are BOTH Network Providers*.*

Note: Payment of Emergency room claims is subject to review by the Claims Administrator. The Claims Administrator makes the final determination regarding whether services were rendered for an Emergency.

Emergency Services Provided by Out-of-Network Providers. Out-of-Network Providers may send you a bill and collect for the amount of the Out-of-Network Provider's charge that exceeds the Maximum Allowed Amount under this Plan. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. This amount can be significant. If you receive a bill, please contact your campus student health services insurance office at 1-831-459-2500 for additional information or assistance. Covered Dependents must contact the Claims Administrator at 1-866-940-8306 for additional information or assistance.

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the back of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

As soon as you enroll in this Plan, you should download our Sydney Health mobile app. You can find details on how to do this on our website, www.anthem.com/ca or contact our Member Services at 1-866-940-8306.Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, www.anthem.com/ca.

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the Claims Administrator's network. You can also find out where they are located and details about their license or training:

- See your Plan's directory of Network Providers at www.anthem.com/ca, choose a plan/network - UC SHIP PPO, which lists the Physicians, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in our mobile app.
- Contact Member Services to request a list of Physicians and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Physician or Provider.

Please note that not all Network Providers offer all services. For example, some hospital-based labs are not part of our Reference Lab Network. In those cases, you will have to go to a lab in the Reference Lab Network to get Network benefits. Please call Member Services before you get services for more information.

If you need details about a Provider's license or training, or help choosing a Physician who is right for you, call the Member Services number on the back of your Member Identification Card (1-866-940-8306). TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Claims Administrator to help with your needs.

Please note that Anthem has several networks, please make sure to choose the UC SHIP PPO network when choosing a provider.

Timely Access to Care

Anthem has contracted with health care service providers to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its contracted provider networks have the capacity and availability to offer appointments within the timeframes specified below. Where there is no In-Network Provider available for Medically

Necessary Covered Services, Anthem may provide a Referral. Please read the “Claims Payment” section for additional information on Referrals.

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with specialists:** within fifteen (15) business days of the request for an appointment;

If a Provider determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the Provider may schedule an appointment for a later time than noted above.

Anthem arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If Anthem contracts with a Provider for telephone triage or screening services, the Provider will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform you of the wait time for a return call from the Provider or how the Member may obtain urgent care or Emergency services or how to contact another Provider who is on-call for telephone triage or screening services. "Triage" or "screening" means the assessment of the Member’s health concerns and symptoms via communication, with a Physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an appointment with a Network Provider.

The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, the Claims Administrator participates in a program called "BlueCard," which provides services to you when you are outside the Service Area. For more details on this program, please see “Inter-Plan Arrangements” in the “Claims Payment” section.

Identification Card

A health app is also available that allows UC SHIP Members and their Dependents to access Plan Identification Cards and benefits information from their mobile devices. To learn more about these services, or if you would like to order a hardcopy of your ID Card, please call UC SHIP Member Services at 1-866-940-8306 or download the Sydney Health app from the App Store or Google Play or visit www.anthem.com/ca. Once you have the app, follow these steps to register:

- Select “Student ID” from the Identification drop down box, enter your student ID number, date of birth (mm/dd/yyyy), first name, last name; then go to the next screen.
- On the next screen, you will be prompted to select two security questions and a password.

The Claims Administrator will provide an electronic Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only covered Members have the right to receive services under this Plan. If anyone gets services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she must pay for the actual cost of the services.

You may not knowingly permit the use of your Plan Identification Card by someone other than yourself or your dependents to obtain services.

Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Year Maximums or limits that apply. Please read the "What's Covered" for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, exclusions, limitations, and terms of this Benefit Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from a Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, non-covered charges, and charges exceeding the out-of-pocket limit. This amount can be substantial. Please read the "Claims Payment" section for more details.

Certain services require prior authorization in order for benefits to be provided. Network Providers will initiate the review on your behalf. An Out-of-Network Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call Anthem directly. Please see "Getting Approval for Benefits" for more details.

Deductibles, Coinsurance, and Benefit Year Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Benefit Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental Health and Substance Use Disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Deductible – Plan Year	Network	Out-of-Network
Per Member	$300	
Per Family – All other Members combined	$600	

All medical services and supplies received outside the student health services that are covered under this Plan are subject to the Benefit Year Deductible, unless otherwise indicated.

The Network and Out-of-Network Deductibles are combined.

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

The Deductible does not include penalties for not getting required Precertification.

The Benefit Year Deductible will not apply to benefits for prescription drugs under your OptumRx Prescription Drug Plan. For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com.

Pediatric Vision Services are not subject to the Deductible.

There is a Pediatric Dental Deductible. Please see "Pediatric Dental Services" for details.

Coinsurance	Network	Out-of-Network
Plan Pays	85%	60%
Member Pays	15%	40%

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount, not the Provider's billed charges. Except for Surprise Billing Claims, if you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. For example, the coinsurance for ambulance services and psycho-educational testing are based upon billed charges. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	Network	Out-of-Network
Per Member	$4,500	$9,000
Per Family – All other Members combined	$9,000	$18,000

The Out-of-Pocket Limit includes all covered medical, prescription drug and pediatric dental Deductibles, Coinsurance, and Copayments you pay during a Benefit Year, including Coinsurance and Copayments at the Student Health Services Center unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. It does not include penalties for not getting required Precertification.

Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Year, but you remain responsible for costs in excess of the Maximum Allowed Amount.

The Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.

Note: Any Copayments or Coinsurance you pay toward your prescription drug benefit will apply towards your Medical and Prescription Drug Out-of-Pocket Limit. For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com.

Important Notice about Your Deductible and Out of Pocket Limit Accrual Balances

The Claims Administrator is required to provide you with the accrual towards your Deductible(s), if any, and Out of Pocket Limit balance(s) every month in which your benefits were used until the accrual balances equal the full amount of the Deductible(s) and/or Out of Pocket Limit(s). If you have questions or wish to opt-out of these mailed accrual notifications and receive the notifications electronically, call the Member Services number on the back of your ID card or access Anthem's website at www.anthem.com/ca.

Important Notice about Your Cost Shares

For certain Covered Services, and depending on your Plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductibles, Coinsurance or Copayments). Your cost share amount may be different depending on whether you received Covered Services from a Network Provider or Out-of-Network Provider. Specifically, you may be required to pay higher cost-share amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" section for your cost share responsibilities and limitations or call the Member Services telephone number (1-866-940-8306) on your Identification Card to learn how this Plan's benefits or cost share amount may vary by the type of Provider you use.

The Claims Administrator will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Network Provider or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances, you may only be asked to pay the lower Network Provider cost share percentage when you use an Out-of-Network Provider. For example, if you go to a Network Hospital or Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital or Facility, you will pay the Network Provider cost share percentage of the Maximum Allowed Amount for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider*'s* charge, called "Balance Billing*." (Please see above exceptions for Out-of-Network Services and Benefits.)*

Emergency Services Provided by Out-of-Network Providers. Out-of-Network Providers may send you a bill and collect for the amount of the Out-of-Network Provider's charge that exceeds the Maximum Allowed Amount under this Plan. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. This amount can be significant. If you receive a bill, please contact your campus student health center insurance office at 1-831-459-2500 for additional information or assistance. Covered Dependents must contact the Claims Administrator at 1-866-940-8306**, as** listed on their Identification Card, for additional information or assistance.

Reduction of The Maximum Allowed Amount for Non-Contracting Hospitals. A small percentage of hospitals which are Out-of-Network Providers are also Non-Contracting Hospitals. Except for Emergency care, the Maximum Allowed Amount **is reduced by 25%** for all services and supplies provided by a Non-Contracting Hospital. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a Contracting Hospital. **You can call Member Services at 1-866-940-8306 to locate a Contracting Hospital**.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases, you should determine where you will receive the service (i.e., in a Doctor's office, at an outpatient Hospital Facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a Doctor's office, an outpatient Hospital Facility, or during an Inpatient Hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."

Member Cost Share

Benefits	Network	Out-of-Network
Abortion	No Copayment, Deductible or Coinsurance	
Acupuncture	See “Therapy Services”	
Allergy Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance Services (Air or Water) Ambulance services are based upon billed charges. **Important Note:** All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see “Getting Approval for Benefits” for details.	No Copayment, Deductible or Coinsurance	
Ambulance Services (Ground) The coinsurance for ambulance services is based upon billed charges. **Important Note:** All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see “Getting Approval for Benefits” for details.	15% Coinsurance after Network Deductible	

Benefits	Network	Out-of-Network
Bariatric Surgery Bariatric Surgery is covered only when performed at a designated Hospital or Ambulatory Surgery Center (BDCSC or UC Family Provider).		
• Inpatient Services (designated Hospital)	15% Coinsurance after Deductible	Not covered
• Outpatient Facility Services (designated Hospital or Ambulatory Surgery Center)	15% Coinsurance after Deductible	Not covered
• Travel expense For an approved, specified bariatric surgery, performed at a designated Hospital or Ambulatory Surgery Center that is fifty (50) miles or more from the Member's place of residence, the following travel expenses incurred by the Member and/or one companion are covered:		
– Transportation to and from the designated Hospital or Ambulatory Surgery Center or Ambulatory Surgery Center for the Member. Limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit.	up to $130 per trip No Deductible	Not covered
– Transportation to and from the designated Hospital or Ambulatory Surgery Center or Ambulatory Surgery Center for the companion. Limited to two (2) trips – the initial surgery and one follow-up visit.	up to $130 per trip No Deductible	Not covered
– Lodging accommodations for the Member and one companion (for the pre-surgical visit and the follow-up visit). Limited to one room, double occupancy.	up to $100 per day, for up to 2 days per trip or as Medically Necessary No Deductible	Not covered
– Lodging accommodations for one companion (for the duration of the Member's initial surgery stay). Limited to one room, double occupancy.	up to $100 per day, for up to 4 days No Deductible	Not covered
– Other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)	up to $25 per day, for up to 4 days per trip No Deductible	Not covered
Important Note: Services must be approved through Precertification. Please see "Getting Approval for Benefits" for details.		

Benefits	Network	Out-of-Network
Behavioral Health Services	See “Mental Health and Substance Use Disorder Services”	
Chemotherapy	See “Therapy Services”	
Chiropractor Services	See “Therapy Services”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
Dental Services for Members Age 19 and Older	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
Dental Services – Pediatric Dental (Members under Age 19)	Please see the separate schedule later in this section.	
Diabetes Equipment and Education Screening for gestational diabetes is covered under "Preventive Care".	$25 Copayment per visit No Deductible	40% Coinsurance after Deductible
Diagnostic Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	Network	Out-of-Network
Durable Medical Equipment (DME), Medical Devices and Supplies	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotics	15% Coinsurance after Deductible	40% Coinsurance after Deductible
The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
• Hearing Aids (benefit maximum of one hearing aid per ear, every four years	15% Coinsurance after Deductible	Not covered
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$200 Copayment per visit No Deductible $200 Copayment waived if admitted 15% Coinsurance apply if admitted See “Inpatient Services”	
• Emergency Room Doctor Charge	No Copayment, Deductible, or Coinsurance	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	No Copayment, Deductible, or Coinsurance	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Copayment, Deductible, or Coinsurance	
Out-of-Network Providers may also bill you for any charges over the Plan’s Maximum Allowed Amount. Please see “Important Notice about Your Cost Shares” for details (page 26).		
As described in the “Consolidated Appropriations Act of 2021 Notice” at the end of this Booklet, for Emergency Services, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan’s Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Consolidated Appropriations Act of 2021 Notice in this Booklet for more details.		

Benefits	Network	Out-of-Network
Fertility Preservation	See "Maternity and Reproductive Health Services	
Gender Affirming Services Gender affirming surgery is covered only when performed with a UC Family or Network Provider.	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	Not covered
Precertification required		
Gender Affirming Surgery Travel Expense		
For an approved specified gender affirming surgery performed at a designated Hospital or Ambulatory Surgery Center that is fifty (50) miles or more from the Member's place of residence, the following travel expenses incurred by the Member and/or one companion are covered:		
– Travel expense – for each surgical procedure (limited to 6 trips)	No Copayment, Deductible, or Coinsurance	Not covered
– Transportation to and from the facility where the surgery will be performed for the Member and one companion.	up to $250 for round trip coach airfare for each person No Deductible	Not covered
– Lodging accommodations for the Member and one companion. Limited to one room, double occupancy.	up to $100 per day, for up to 21 days per trip No Deductible	Not covered
– Other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)	up to $25 per day, for each person, for up to 21 days per trip No Deductible	Not covered
Important Note: Services must be approved through Precertification. Please see "Getting Approval for Benefits" for details.		

Benefits	Network	Out-of-Network
Gene Therapy Services Precertification required	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
Habilitative Services	Benefits are based on the setting in which Covered Services are received.	
Hemodialysis	See “Therapy Services”	
Home Health Care		
• Home Health Care Visits (including intermittent skilled nursing services) (up to 4 hours each visit, In- and Out-of-Network combined)	No Copayment or Coinsurance	40% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	No Copayment or Coinsurance	40% Coinsurance after Deductible
Important Note: Please refer to the section “Getting Approval for Benefits” for more details.		
Home Infusion Therapy	See “Therapy Services”	
Hospice Care		
• Home Health Care • Respite Hospital Stays	15% Coinsurance	40% Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan’s Maximum Allowed Amount. This Plan’s Hospice benefit will meet or exceed Medicare’s Hospice benefit. If you use an Out-of-network Provider, that Provider may also bill you for any charges over Medicare’s Hospice benefit.		

Benefits	Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Immunizations	See “Preventive Care”	
Inpatient Services Facility Room & Board Charge:		
• Hospital / Acute Care Facility	15% Coinsurance after Deductible	$500 Copayment per admission plus 40% Coinsurance after Deductible plus an additional 25% Non-Contracting Hospital Penalty*
• Skilled Nursing Facility	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
***Non-Contracting Hospital Penalty.** The Maximum Allowed Amount is **reduced by 25%** for services and supplies provided by a Non-Contracting Hospital. This penalty will be deducted from the Maximum Allowed Amount prior to calculating your Co-Insurance amount, and any benefit payment will be based on such reduced Maximum Allowed Amount. You are responsible for paying this extra expense. This reduction will be waived only for Emergency Services. To avoid this penalty, be sure to choose a Contracting Hospital.		
Doctor Services for:		
• General Medical Care / Evaluation and Management (E&M) (Physician services for physicians that bill separately from the hospital charge)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Surgery (Physician services for physicians that bill separate from the hospital charge)	15% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	Network	Out-of-Network
Lactation Consultation	See "Maternity and Reproductive Health Services"	
LiveHealth Online Medical Services	$10 Copayment per visit No Deductible	Not applicable
LiveHealth Online Services – Mental Health	No Copayment or Deductible	Not applicable
Maternity and Reproductive Health Services		
• Inpatient Services (Delivery)	See “Inpatient Services”	
• Maternity Visits (Global fee for the ObGyn’s delivery services) If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Preconception, Prenatal and Postnatal care, including routine prenatal and postnatal office visits, tests, ultrasound and other maternity services (i.e. diagnostic imaging, lab & supplies)	$10 Copayment for the initial prenatal visit. No Deductible No Deductible No Copayment, or Coinsurance after initial visit. If you obtain services other than Prenatal Office Visits, please see that setting for your Copayment / Coinsurance	40% Coinsurance after Deductible

Benefits	Network	Out-of-Network
• Lactation Consultation (when provided by IBCLC), limited to $200 per visit	No Copayment, Deductible, or Coinsurance	
• Lactation Consultation (when provided by all other providers)	No Copayment or Coinsurance	40% Coinsurance after Deductible
• Fertility Preservation (See Maternity and Reproductive Health Services in "What's Covered")	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Medical Evacuation		
• For all covered services, limited $50,000 per trip	No Copayment, Deductible, or Coinsurance	
Mental Health and Substance Use Disorder Services (includes behavioral health treatment for Autism Spectrum Disorders)		
Inpatient Services		
• Inpatient Facility Services	15% Coinsurance after Deductible	$500 Copayment per admission plus 40% Coinsurance after Deductible plus an additional 25% Non-Contracting Hospital Penalty*
• Residential Treatment Center Services	15% Coinsurance after Deductible	$500 Copayment per admission plus 40% Coinsurance after Deductible plus an additional 25% Non-Contracting Hospital Penalty*
• Inpatient Provider Services (e.g. Doctor and other professional Providers)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	15% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	Network	Out-of-Network
• Outpatient Facility Services (Intensive Outpatient Program) for Substance Use Disorder and Eating Disorder	15% Coinsurance No Deductible	40% Coinsurance after Deductible
• Outpatient Provider Services (e.g. Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Outpatient Provider Services (Intensive Outpatient Program) for Substance Use Disorder and Eating Disorder	15% Coinsurance No Deductible	40% Coinsurance after Deductible
• Office Visits (Intensive In-Home Behavioral Health Programs) – Individual / group mental health evaluation and treatment – Individual / group chemical dependency counseling – Medical treatment for withdrawal symptoms	No Copayment or Deductible	40% Coinsurance after Deductible
• **Telehealth - Mental Health**	No Copayment or Deductible	40% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” and the “Federal Notices” section for details. ***Non-Contracting Hospital Penalty.** The Maximum Allowed Amount is **reduced by 25%** for services and supplies provided by a Non-Contracting Hospital. This penalty will be deducted from the Maximum Allowed Amount prior to calculating your Co-Insurance amount, and any benefit payment will be based on such reduced Maximum Allowed Amount. You are responsible for paying this extra expense. This reduction will be waived only for Emergency Services. To avoid this penalty, be sure to choose a Contracting Hospital.		
Occupational Therapy	See “Therapy Services”	
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. Note: There will be no Copayment for services obtained from the Student Health Center (SHS).		

Benefits	Network	Out-of-Network
• Primary Care Physician / Provider (PCP)	$10 Copayment per visit No Deductible	40% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP)	$10 Copayment per visit No Deductible	40% Coinsurance after Deductible
• Abortion	No Copayment, Deductible or Coinsurance	
• Allergy Testing	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Preferred Diagnostic Lab (non-preventive) i.e., reference labs	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (non-preventive; including hearing and EKG)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery (including anesthesia)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME), Medical Devices and Supplies”	

Benefits	Network	Out-of-Network
Outpatient Facility Services		
• Facility Surgery Charge	15% Coinsurance after Deductible	40% Coinsurance after Deductible plus an additional 25% Non-Contracting Hospital Penalty*
• Ambulatory Surgery Center	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Surgery Charges	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms or other ancillary services)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in an Outpatient Facility	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	See “Therapy Services”	

Benefits	Network	Out-of-Network
Preventive Care	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Prosthetics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies”	
Psycho-Educational Testing ($4,500 benefit maximum during a Member’s lifetime while covered by UC SHIP)	15% Coinsurance after Deductible	
Radiation Therapy	See “Therapy Services”	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Repatriation of Remains • For all covered services, limited to $25,000	No Copayment, Deductible, or Coinsurance	
Services Outside of the United States	Based on Setting of Covered Services*	40% Coinsurance after Deductible
*With a Guarantee of Payment through BCBS Global Core® in place, Network benefits apply, based on the setting in which Covered Services are received. Please refer to the “BCBS Global Core® Program” section in this Benefit Booklet for details on contacting BCBS Global Core®.		

Benefits	Network	Out-of-Network
Note about UC Travel Insurance: The UC Office of the President purchases a travel accident policy for students traveling to foreign countries to participate in University sponsored academic programs, University research projects or other University related purposes at no additional cost to the students. For more information about this benefit and to register for the program, please go to: https://www.ucop.edu/risk-services-travel/index.html This insurance provides emergency medical assistance, as well as many other benefits. To ensure you receive access to the full spectrum of benefits, it is highly recommended that you register your travel at the website listed above prior to your trip. Registration is simple and takes less than 5 minutes.		
Skilled Nursing Facility	See "Inpatient Services"	
Speech Therapy	See "Therapy Services"	
Sterilization Procedures for Men	15% Coinsurance after the Deductible	40% Coinsurance after Deductible
Surgery	Benefits are based on the setting in which Covered Services are received.	
Telehealth (Medical) Primary Care Physician / Provider (PCP) Specialty Care Physician / Provider (SCP)	$10 Copayment per visit No Deductible	40% Coinsurance after Deductible
Telehealth (Mental Health)	No Copayment or Deductible	40% Coinsurance after Deductible
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	

Benefits	Network	Out-of-Network
Therapy Services		
• Acupuncture (office setting)	$25 Copayment per visit No Deductible	40% Coinsurance after Deductible
• Chiropractic / Osteopathic / Manipulation Therapy	$25 Copayment per visit No Deductible	40% Coinsurance after Deductible
• Physical, Speech, & Occupational Therapy	$25 Copayment per visit No Deductible	40% Coinsurance after Deductible
• Chemotherapy	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Hemodialysis	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Infusion Therapy (in any setting)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
• Radiation Therapy	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Transplant Services	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services”	

Benefits	Network	Out-of-Network
Urgent Care Services (Office and Home* Visits) *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Visit Charge	$25 Copayment per visit No Deductible	40% Coinsurance after Deductible
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
Vision Services – Pediatric Vision (Members under Age 19)	Please see the separate summary later in this section.	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call the Transplant Department at 1-800-824-0581 as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from the Centers of Medical Excellence (CME), Blue Distinction Centers for Specialty Care (BDCSC) or a UC Family Provider.

The Claims Administrator provides access to Centers of Medical Excellence (CME) networks and Blue Distinction Centers for Specialty Care (BDCSC). Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for certain transplant services. **These procedures are covered only when performed at a CME, BDCSC or by a UC Family Provider.**

Please call to find out which Hospitals are Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

The facilities included in each of these networks are selected to provide the following specified medical services:

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

The requirements described below do not apply to the following:

- Cornea transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the “What’s Covered” section for additional details.

Covered Transplant Procedure during the Transplant Benefit Period	Network	Out-of-Network
Transplant Benefit Period	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility.	Not covered
Inpatient Facility Services • **Precertification required**	During the Transplant Benefit Period, 15% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	Not covered
Inpatient Professional and Ancillary (non-Hospital) Services	15% Coinsurance after Deductible	Not covered
Outpatient Facility Services	15% Coinsurance after Deductible	Not covered
Outpatient Professional and Ancillary (non-Hospital) Services	15% Coinsurance after Deductible	Not covered

Covered Transplant Procedure during the Transplant Benefit Period	Network Professional and Ancillary (non-Hospital) Providers	Out-of-Network Professional and Ancillary (non-Hospital) Providers
Transplant Travel		
• Transportation and Lodging Limit	Travel Expense Benefits are payable only if the specific CME, BDCSC or UC Family is 50 miles or more from the recipient or donor's home	Not Covered
– Transportation to and from the designated Hospital for the Member and one companion. Limited to six (6) trips per episode.	up to $250 per trip for each person for round trip coach airfare No Deductible	Not Covered
– Lodging for the Member and one companion. Limited to one room, double occupancy	up to $100 per day for up to 21 days per trip No Deductible	Not Covered
– Other reasonable expenses (excluding, tobacco, alcohol, drug, and meal expenses)	up to $25 per day, for each person for up to 21 days per trip No Deductible	Not Covered
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	15% Coinsurance after Deductible	Not covered

	Network	Out-of-Network
Live Donor Health Services	15% Coinsurance after Deductible	Not covered
• **Inpatient Facility Services**	15% Coinsurance after Deductible	Not covered
• **Outpatient Facility Services**	15% Coinsurance after Deductible	Not covered
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	
• **Transportation and Lodging Limit**		
– Transportation to the designated Hospital for the donor. Limited to one (1) trip per episode.	up to $250 for round trip coach airfare No Deductible	Not Covered
– Lodging for the donor. Limited to one room, double occupancy	up to $100 per day for up to 7 days No Deductible	Not Covered
– Other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses)	up to $25 per day for up to 7 days No Deductible	Not Covered

Pediatric Dental Services

Benefit Year Deductible	Network and Out-of-Network
Per Member/Family	$60/$120

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

Payment Rates	Network	Out-of-Network
Plan Pays	50%	50%
Member Pays	50%	50%

After the Pediatric Dental Deductible has been satisfied, the Plan will pay the percentage of the Maximum Allowed Amount shown below, for the type of services received, up to the Maximum Allowed Amount.

Out-of-Pocket Limit	Network and Out-of-Network
Per Member	$1,000
Per Family – All other Members combined	$2,000

After you have made the following total out-of-pocket payments for covered charges incurred during a Benefit Year, you will no longer be required to pay a Copayment or Coinsurance for the remainder of that Benefit Year, but you remain responsible for costs in excess of the Maximum Allowed Amount.

Benefits	Network	Out-of-Network
Diagnostic & Preventive Services For example: • Periodic oral exam • Teeth cleaning • Bitewing X-rays	No Copayment, No Deductible	No Copayment, No Deductible
Basic Services - Fillings For example: • Amalgam (silver-colored) • Anterior (front) composite (tooth-colored) • Posterior (back) composite covered at amalgam allowance	50% Coinsurance	50% Coinsurance
Endodontic Services For example: • Root canal	50% Coinsurance	50% Coinsurance
Periodontal Services For example: • Scaling and root planning	50% Coinsurance	50% Coinsurance
Oral Surgery Services	50% Coinsurance	50% Coinsurance
Major Services For example: • Crowns	50% Coinsurance	50% Coinsurance
Prosthodontic Services For example: • Dentures • Bridges	50% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Services	50% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Maximum	No Maximum	No Maximum
Cosmetic Orthodontic Services	Not covered	Not covered

Pediatric Vision Services

Payment Rates	Network	Out-of-Network
Member Pays	No Copayment	No Copayment

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

Members are covered until the last day of the month in which the individual turns nineteen (19) years of age.

Pediatric Vision Services are not subject to the Deductible.

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

Out-of-Network Vision Care Provider Copayments. There will be no Copayment required for services and supplies provided by an out-of-network vision care provider, but, you will be responsible for any billed charge which exceeds the vision care Maximum Allowed Amount as shown below.

Benefit	Network	Out-of-Network
Routine Eye Exam – Once every Benefit Year	No Copayment	No Copayment up to a Maximum Allowed Amount of $30
Comprehensive Low Vision Exam – Once every five (5) Benefit Years	No Copayment	Not covered
Low Vision Follow up Visits – Up to four (4) visits in any five (5) Benefit Years	No Copayment	Not covered
Optical/Non-optical Aids – Up to one (1) per Benefit Year	No Copayment	Not covered
Frames* (Formulary) – Once every Benefit Year	No Copayment	No Copayment up to a Maximum Allowed Amount of $45

Benefit	Network	Out-of-Network
Standard Plastic or Glass Lenses – Once every Benefit Year The following lens options are included at no extra cost when received from a Network Provider*:* – Transition lenses – Plastic photosensitive lenses – Polarized lenses – Standard polycarbonate – Factory scratch coating – UV coating – Anti-reflective coating (standard, premium or ultra) – Tint (fashion and gradient) – Oversized and glass-grey #3 prescription sunglass lenses – Blended segment lenses – Intermediate vision lenses – High index lenses		
Single Vision	No Copayment	No Copayment up to a Maximum Allowed Amount of $25
Bifocal	No Copayment	No Copayment up to a Maximum Allowed Amount of $40
Trifocal	No Copayment	No Copayment up to a Maximum Allowed Amount of $55
Lenticular	No Copayment	No Copayment up to a Maximum Allowed Amount of $70
Progressive (standard, premium, select or ultra)	No Copayment	No Copayment up to a Maximum Allowed Amount of $40
Contact Lenses* (Formulary) – A (1) one year supply of contact lenses instead of eyeglass lenses – Fitting, evaluation, and follow-up care for both elective and non-elective contact lenses are included in the contact lens benefit		
Elective (Conventional or Disposable) Lenses; or	No Copayment, Formulary	No Copayment up to a Maximum Allowed Amount of $60
Non-Elective Contact Lenses	No Copayment	No Copayment up to a Maximum Allowed Amount of $40
*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this “Schedule of Benefits”.		

Getting Approval for Benefits

Most services require a Referral from the Student Health Center before seeking care off campus, except for Emergency care, urgent care, LiveHealth Online, pediatric dental or vision for members under age 19, services of a pediatrician, obstetrician, or gynecologist. Your Plan also includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different provider or facility my need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the information in this section, you may call the UC SHIP Member Services at 1-866-940-8306.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it's decided your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.

- **Precertification –** A required Pre-service Review, for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Benefit Booklet.

  For admission following Emergency Care, you, your authorized representative, or Doctor must notify the Claims Administrator of the admission as soon as possible. For labor/ childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Predetermination –** An optional, voluntary Review request for a benefit coverage determination for a service or treatment if there is a related clinical coverage guideline. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Benefit Booklet.

- **Continued Stay / Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Pre-service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage determination that is conducted after the service has been provided. Post-service Reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained, or a Predetermination review was not performed. Post-service Reviews are done for a service, treatment, or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Services for which Precertification is required (i.e., services that need to be reviewed by the Claims Administrator to determine whether they are Medically Necessary) include, but are not limited to, the following:

1. Admissions to a Skilled Nursing Facility if you require daily skilled nursing or rehabilitation, as certified by your attending Physician.
2. Air ambulance services for non-Emergency Hospital to Hospital transfers.
3. Certain non-Emergency ground ambulance services
4. Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense 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 BDCSC facility or by a UC Family provider.
5. Behavioral health treatment for Autism Spectrum Disorders.

6. Fertility Preservation and related Covered Services.

7. Home health care. The following criteria must be met:

   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 Care Agency.

8. Scheduled, non-emergency inpatient Hospital stays and Residential Treatment Center admissions.

   Exceptions: Utilization review is not required for Inpatient Hospital stays for the following services:

   a. Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and

   b. Mastectomy in association with a breast cancer diagnosis and lymph node dissection.

9. 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.

10. Gender Affirming surgery benefits and related Covered Services will be provided as follows:

    a. The Surgical Procedure:

       - The services are Medically Necessary and appropriate*;* and

       - The physicians on the surgical team and the facility in which the surgery is to take place are approved for the gender affirming surgery requested.

       - Precertification is required for certain services.

    b. Gender Affirming Surgery Travel Expense:

       - It is for gender affirming surgery and related services, authorized by the Claims Administrator; and

       - The gender affirming surgery must be performed at a specific facility designated by the Claims Administrator which is approved for the gender affirming surgery requested.

11. Transplant services including transplant travel expense. The following criteria must be met for certain transplants, as follows:

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

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

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed, or ask for a Predetermination, even though it is not required. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and they are responsible for meeting these requirements. If services are requested at an out-of-network, non-participating provider, or Blue Card provider, you are responsible to obtain the Precertification. When you are travelling abroad and need medical care, you can call Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification or Predetermination review. However, you may request a Precertification or Predetermination or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to get Precertification	Comments
Network	Provider	• The Provider must get Precertification when required
Out-of-Network / Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
BlueCard Provider	Member **(except for Inpatient Admissions)**	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
Blue Cross Blue Shield Global Core® Program	Member	• Member must get Precertification when required. (Call Blue Cross Blue Shield Global Core Service Center at 800-810-2583 or call collect at 804-673-1177.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.

Note: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative, or Doctor must tell us of the admission as soon as possible.

How Decisions Regarding Medical Necessity are Made

The Claims Administrator will use clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number at 1-800-274-7767, which also appears on the back of your Identification Card. You can also find our medical policies on our website at www.anthem.com.

If you are not satisfied with the Claims Administrator's decision under this section of your benefits, please refer to the "Your Right to Appeals" section to see what rights may be available to you.

Decision and Notification Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal regulations. You may call 1-866-940-8306 for additional information.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Concurrent / Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Concurrent / Continued Stay Review Urgent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Concurrent / Continued Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

If more information is needed to make their decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If Claims Administrator does not get the specific information needed by the required timeframe, a decision will be made based upon the information received.

The Claims Administrator will give notice to you and your Provider of its decision as required by state and federal regulations. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

The Claims Administrator may, from time to time, waive, enhance, change, or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in its sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

The Claims Administrator may also select certain qualifying Providers to take part in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that the Claims Administrator will do so in the future or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Member Services number at1-866-940-8306, which is indicated on the back of your Identification Card.

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

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) helps coordinate services for Members with health-care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

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

If you meet program criteria and agree to take part in, the Claims Administrator will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Physician(s), and other Providers.

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

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Year Maximums of this Plan. The Claims Administrator will make its decision case-by-case, if in the Claims Administrator's discretion, the alternate or extended benefit is in the best interest of you and the Plan, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Your Covered Services are subject to all the terms and conditions listed in this Benefit Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, exclusions, and Medical Necessity requirements. Please refer to the "Schedule of Benefits" for details on the amounts you are required to pay for Covered Services and for details on any Benefit Maximums. Also be sure to refer to the "How Your Plan Works" section for additional information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have a surgery, benefits for your Hospital stay will be described under "Hospital Services" and benefits for your Physician's services will be described under "Physician's Services." As a result, you should review all benefit descriptions that might apply to your claims.

You should also be aware that many of the Covered Services can be received in several settings, including a Physician's office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to receive Covered Services, and this can result in a change in the amount you will need to pay. Please see the "Schedule of Benefits" for more details.

Acupuncture

Please see "Therapy Services" later in this section.

Adverse Childhood Experiences Screenings

Benefits for provided for screenings for an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service as described in this section when you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non-Emergency ambulance transportation, including psychiatric transportation for safety issues. Ambulance Services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider

Ambulance services are a Covered Service when one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or

- Between a Hospital or Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or
  - Between a Hospital and an approved Facility.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

You must be taken to the nearest Facility that can give care for your condition. In certain circumstances the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

a) A Doctor's office or clinic;

b) A morgue or funeral home.

If provided through the 911 Emergency response system or the 988 suicide and crisis lifeline call, ambulance charges are covered if it is reasonably believed that a medical Emergency existed even if you are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by us prior to the benefits being paid.

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM OR A 988 SUICIDE AND CRISIS LIFELINE HAS BEEN ESTABLISHED. THESE SYSTEMS ARE TO BE USED ONLY WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 911, 988 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a *physician's* office or to your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

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

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

Autism Spectrum Disorders Services

Benefits are provided for behavioral health treatment for autism spectrum disorders. This coverage is provided according to the terms and conditions of this Benefit Booklet that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this Plan are subject to the same Deductibles, Coinsurance, and Copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under Plan benefits that apply for office visits to Physicians, whether services are provided in the Provider's office or in the patient's home. Services provided in a Facility, such as the outpatient department of a Hospital, will be covered under Plan benefits that apply to such Facilities.

Behavioral Health Treatment
The behavioral health treatment services covered by this Benefit Booklet are those professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorders and that meet all of the following requirements:

- The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,

- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider, and

- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that

imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

- Describes the patient's behavioral health impairments to be treated,
- Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Autism Spectrum Disorders, and
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan must not be used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and must not be used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to us upon request.

Our network of Providers is limited to licensed Qualified Autism Service Providers who contract with Anthem and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Autism spectrum disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Qualified Autism Service Professional is a Provider who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is either of the following:
    - a behavioral service Provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an

associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, or

- a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology, and who is deemed to meet the criteria set forth in the Welfare and Institutions Code for a Behavioral Health Professional,

- Has training and experience in providing services for autism spectrum disorders pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider is either of the following:

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

You must obtain Precertification for all behavioral health treatment services for the treatment of Autism Spectrum Disorders in order for these services to be covered. No benefits are payable for these services if Precertification is not obtained (see the "Getting Approval for Benefits" section for details).

Behavioral Health Services

See "Mental Health and Substance Use Disorder Services" later in this section.

Breast Cancer

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

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered under the Preventive Care Services benefit.
2. Breast cancer (BRCA) testing, if appropriate as determined by your Physician, in conjunction with genetic counseling and evaluation. When done as a preventive care service, BRCA testing will be covered under the Preventive Care Services benefit.
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy.
5. Breast prostheses following a mastectomy (see "Durable Medical Equipment (DME), Medical Devices and Supplies").

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

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic and Osteopathic Services

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. A “qualified insured” means that you meet both of the following conditions:

a) You are eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

b) Either of the following applies:
   i. The referring health care professional is an In-Network Provider and has concluded that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).
   ii. You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition. The term “life-threatening disease or condition” means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits are limited to the following trials:

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

- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

If one or more In-Network Providers is conducting an approved clinical trial, your Plan may require you to use an In-Network Provider to utilize or maximize your benefits if the In-Network Provider accepts you as a clinical trial participant. It may also require that an approved clinical trial be located in California, unless the clinical trial is not offered or available through an In-Network Provider in California.

Routine patient care costs include drugs, items, devices, and services provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan, including:

- Drugs, items, devices, and services typically covered absent a clinical trial;
- Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service;
- Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;
- Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service;
- Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

Cost sharing (Copayments, Coinsurance, and Deductibles) for routine patient care costs will be the same as that applied to the same services not delivered in a clinical trial, except that the In-Network cost sharing and Out-of-Pocket Limit will apply if the clinical trial is not offered or available through an In-Network Provider.

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

Your Plan is not required to provide benefits for the following services and reserves the right to exclude any of the following services:

- The Investigational item, device, or service; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Note: Please see the Delta Dental Benefit Booklet for additional dental plan benefits available to you.

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and preparation for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Dental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by the Accidental Injury and/or to restore function lost as a direct result of the Accidental Injury. Damage to natural teeth due to chewing or biting is not considered an Accidental Injury.

Admissions for dental services up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.

Other Dental Services

Benefits are available for Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Dental Services – Pediatric

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

Diagnostic and Preventive Services

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

Basic Restorative Services

- Restorations (fillings) – covered as follows:
  - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries (decay). If the tooth can be restored with these materials, any other restoration, such as a crown, is considered an optional treatment
  - Composite resin or acrylic restorations on posterior (back) teeth is an optional treatment
  - Micro filled resin restorations that are non-cosmetic
  - Replacement of a restoration is covered only if it is defective, as evidenced by conditions such as recurrent decay or fracture
- Pins and pin build-up – covered only when given with a restoration
- Sedative base and sedative fillings

- Basic tooth extractions – including post-operative care such as exams, suture removal, and treatment of complications.
- Endodontic Services
- Direct pulp capping
- Therapeutic pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy – including culture canal, and retreatment of previous root canal therapy limited as follows:
  - Retreatment of root canals covered only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms
  - Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit
  - Apicoectomy
  - Vitality tests

Periodontal Services

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

Adjunctive General Services

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

Oral Surgery Services

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

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

Major Restorative Services

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

  - Veneers posterior to the second bicuspid are considered and optional treatment. We will pay up to the allowance for a cast full crown
- Recementation of crowns, inlays, and onlays
- Cast post and core, including cast retention under crowns
- Crown repair

Prosthodontic Services

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

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

- Recementation of bridges
- Repair or replacement of abutments or pontics
- Dentures – including full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers. Dentures are covered as follows:
  - Replacement for partial dentures is not covered within 36 months of initial placement unless:
  - It is necessary due to natural tooth loss where the addition or replacement of the existing partial is not possible; or
  - The denture is unsatisfactory and cannot be made satisfactory
  - Coverage for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen, and is not necessary to satisfactorily restore an arch, the patient is responsible for all additional charges
  - A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Any other treatments for these cases are considered optional treatments.
  - Full upper and/or lower dentures are not to be replaced within any 36-month period unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair
  - Coverage for complete dentures will be limited to the benefit for a standard procedure. If a more personalized or specialized treatment is chosen, the patient will be responsible for all additional charges
- Chairside or laboratory relines or rebases – Covered one per arch in any 12-month period
- Denture repairs and adjustments
- Tissue conditioning – limited to two per denture
- Denture duplication
- Stayplates – Covered only when used as anterior space maintainers for children

Orthodontic Treatment

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

Medically Necessary Orthodontic Care

Medically Necessary services will be subject to review. To be considered Medically Necessary, the service must meet criteria for Medically Necessary care as established by the Claims Administrator. The Plan will cover orthodontic care when it is Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat Emergency and urgent conditions.

Your dental provider should submit a prior authorization form to Anthem for this service. This form is available by calling the telephone number listed on your Identification Card or online at www.anthem.com/ca. You may call Member Services at 1-866-940-8306 to ask that a prior authorization form be faxed to your dentist.

The prior authorization process is outlined below:

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

The following conditions automatically qualify for Medically Necessary orthodontic care.

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

Orthodontic treatment may include the following:

- Limited Treatment – Treatments which are not full treatment cases and are usually done for minor tooth movement
- Interceptive Treatment – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment
- Comprehensive (complete) Treatment – Full treatment includes all radiographs, diagnostic casts/models, appliances and visits

- Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth
- Fixed Appliance Therapy – A component that is cemented or bonded to the teeth
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth

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

What Orthodontic Care Does NOT Include. Coverage is NOT provided for:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment
- Retreatment and services given due to a relapse
- Inpatient or Outpatient Hospital expenses, unless covered by the medical benefits of this Plan
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Orthodontic Payments

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

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

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

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

Timely Access to Dental Care

Anthem has contracted with dental Providers to provide covered services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its network of contracted dentists has the capacity and availability to offer appointments within the following timeframes:

- Urgent care appointments: within 72 hours of the request for an appointment;
- Non-urgent appointments for primary care: within 36 business days of the request for an appointment; and
- Preventive dental care appointments: within 40 business days of the request for an appointment.

If In Network dental Provider determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the In Network dental Provider may schedule an appointment for a later time than noted above.

In Network dental Providers are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how You can obtain urgent or Emergency

Care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or Emergency Care.

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of Your appointment.

Diabetes Equipment, Education, and Supplies

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

1. The following equipment and supplies:

    a. Glucose monitors, including monitors designed to assist the visually impaired, and glucose testing strips;

    b. Insulin pumps;

    c. Pen delivery systems for insulin administration (non-disposable);

    d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin; and

    e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

    Items a through d above are covered under your Plan's benefits for durable medical equipment (see Durable Medical Equipment). Item e above is covered under your Plan's benefits for Prosthetic Devices (see "Durable Medical Equipment (DME), Medical Devices and Supplies ").

2. Diabetes education program which:

    a. Is designed to teach a Member who is a patient and members of the patient's family about the disease process and the daily management of diabetic therapy;

    b. Includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and

    c. is provided by appropriately licensed or registered health care professional.

    Diabetes Outpatient Self-Management Training Program services are covered based on the setting in which Covered Services are received.

3. The following items are covered as medical supplies:

    a. Insulin syringes and disposable pen delivery systems for insulin administration. **NOTE:** Charges for insulin and other prescriptive medications are not covered as part of your medical plan. See your pharmacy benefits plan booklet for information on prescriptive medications.

    b. Testing strips, lancets and alcohol swabs.

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

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered prior to a surgical procedure or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services is subject to change as medical technologies change.

Durable Medical Equipment (DME), Medical Devices and Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is intended for use outside a medical Facility.
- Is for the exclusive use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Covered Services include but are not limited to:

- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.

- Dry pressure pad for a mattress.
- IV pole.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by the Claims Administrator. The Plan may limit the amount of coverage for ongoing rental of equipment The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as associated supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered 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.

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

These items and services are covered under your Plan's benefits for durable medical equipment ("Durable Medical Equipment (DME), Medical Devices and Supplies").

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 "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies").

Note: Hearing aids are not covered if provided by an Out-of-Network Provider.

Orthotics and Special Footwear

Benefits are available for Medically Necessary Special Footwear, certain types of orthotics (braces, boots, splints), and services for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina

bifida, diabetes, accident, injury, or developmental disability. Covered Services include the initial purchase, fitting, adjustment and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

1) Artificial limbs and accessories;
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
3) Breast prosthesis (whether internal or external) and surgical bras following a mastectomy, as required by the Women's Health and Cancer Rights Act.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5) Restoration prosthesis (composite facial prosthesis)
6) Cochlear implants
7) Wigs needed after cancer treatment
8) Hearing aids. This includes bone-anchored hearing aids.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration and blood products unless they are received from a community source, such as a blood donated through a blood bank.

Diabetes Equipment and Supplies

See "Diabetes Equipment, Education, and Supplies" earlier in this section.

Asthma Treatment Equipment and Supplies

Benefits are available for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

Emergency Care Services

If you are experiencing an Emergency, please call the 911 Emergency response system or 988 suicide and crisis lifeline or visit the nearest Hospital for treatment.

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition" means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health or the health of another person in serious jeopardy or, for a pregnant women, placing the women's health or the health of her unborn child in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by the Claims Administrator.

Emergency Care

"Emergency Care" means a medical or behavioral health exam done in the Emergency Department of a Hospital and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Medically Necessary services will be covered whether you get care from a Network or Out-of-Network Provider.

Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. For Surprise Billing Claims, the Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the "Consolidated Appropriations Act of 2021 Notice" at the back of this Booklet. Your cost shares will be based on the Recognized Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

Emergency Care you get from an Out-of-Network Provider will be covered, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be:

1. The amount negotiated with Network Providers for the Emergency service furnished;
2. The amount for the Emergency service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls the Claims Administrator as soon as you are stabilized. The Claims Administrator will review your care to decide if a Hospital stay is authorized and how many days they will approve. See "Getting Approval for Benefits" for more details.

Treatment you get after your condition has stabilized will be covered as Medically Necessary according to your attending Physician. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the back of this Booklet for more details on how this will impact your benefits.

Gender Affirming Services

Benefits are provided for services and supplies in connection with Gender Transition when a Physician has diagnosed you with Gender Dysphoria. This coverage is provided according to the terms and conditions of this Benefit Booklet that apply to all other medical conditions, including Medical Necessity requirements, utilization management, and exclusions for cosmetic services. Gender affirming surgery is covered only when performed with a UC Family or Network Provider.

Coverage includes, but is not limited to, Medically Necessary services related to Gender Transition such as gender affirming surgery (i.e., female to male top surgery, female to male bottom surgery, male to female top surgery and male to female bottom surgery), hormone therapy, fertility preservation, psychotherapy, electrolysis and laser hair removal, facial reconstruction, tracheal shave, and vocal training. Coverage is provided for specific services according to benefits under this Benefit Booklet that apply to that type of service generally if the Plan includes coverage for the service in question. For example, gender affirming surgery would be covered on the same basis as any other Network covered, Medically Necessary surgery or hormone therapy would be covered under this Benefit Booklet's benefits.

Some services are subject to precertification in order for coverage to be provided. Please refer to "Getting Approval for Benefits" for information on how to obtain the proper reviews.

Gender Affirming Surgery Travel Expense

The following travel expenses in connection with an authorized gender affirming surgery performed at a designated Hospital or Ambulatory Surgery Center only when the Member's home is fifty (50) miles or more from the nearest provider. All travel expenses must be approved by the Claims Administrator in advance and approved for the gender affirming surgery requested, provided the expenses are authorized by the Claims Administrator (Please refer to the "Getting Approval for Benefits" section for details) for up to six trips:

a. Round trip coach airfare , train, or public transportation to and from the Facility which is designated by the Claims Administrator and approved for the gender affirming surgery requested, not to exceed $250 per person per trip;

b. Lodging accommodations, which is designated by the Claims Administrator and approved for gender affirming surgery requested, not to exceed $100 per day for up to 21 days per trip, limited to one room, double occupancy; and

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

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call Member Services at 1-866-940-8306 for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the approved Facility is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the gender affirming procedure; telephone calls; laundry; postage; or entertainment.

If a specific benefit is not listed or described in the Gender Affirming Services section, the service will not be covered.

Gene Therapy Services

Your Plan includes benefits for gene therapy services when Anthem approves the benefits in advance through Precertification. See “Getting Approval for Benefits” for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call Member Services to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

ii. Services provided by a non-approved Provider or at a non-approved Facility; or

iii. Services not approved in advance through Precertification.

Genetic Testing

Genetic testing for individuals to assess their risk for a variety of conditions.

Note: Testing is only available according to the Claims Administrator’s clinical guidelines. If you have any questions about the information in this section, please refer to the Claims Administrator’s website at www.anthem.com/ca or you may call the UC SHIP Member Services at 1-866-940-8306 for more information.

Habilitative Services

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

Please see "Therapy Services" later in this section for further details.

HIV Testing

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

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to Hospital stay, and be physically unable to obtain needed medical services on an outpatient basis. Services must be prescribed by a Physician and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health personnel.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by the Claims Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider or other Provider as approved by the Claims Administrator
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease.
Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

1. Care from an interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
3. Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
4. Social services and counseling services from a licensed social worker.
5. Nutritional support, such as intravenous feeding and feeding tubes
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
7. Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
8. Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea) are covered like any other surgery, under the regular Inpatient and outpatient benefits described elsewhere in this Benefit Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Benefit Booklet.

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

Any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Centers of Excellence (COE) Transplant Providers

- **Blue Distinction Center (BDC) Facility**: Blue Distinction facilities have met or exceeded national quality standards for transplant care delivery.

- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for transplant care delivery.

- UC Family Provider

Network Transplant Provider

A Provider that we have chosen and designated as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network.

A Provider may be a Network Transplant Provider for:
- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence for Transplant by the Claims Administrator or has not been selected to take part as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a solid organ Covered Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Case Manager at 1-800-824-0581 for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts the day of a Covered Transplant Procedure and lasts until the date of discharge.

Specified Transplants

You must obtain the Claims Administrator's prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) or UC Family Provider. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME, BDCSC or a UC Family Provider will not be considered covered.** Call the toll-free telephone number for pre-service review on your ID card if your Physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME, BDCSC or UC Family Provider. See "Getting Approval for Benefits" for details.

Prior Approval and Precertification

To maximize your benefits, you should call the Claims Administrator's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. They will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Network Transplant Provider rules, or exclusions apply.

Call Member Services at 1-866-940-8306 and ask for the transplant coordinator. Even if you are given a prior approval for the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Physician must certify, and the Claims Administrator must agree, that the transplant is Medically Necessary. Your Physician should send a written request for Precertification to the Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

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

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

- If a covered Member under this Plan is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 50 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to the Claims Administrator when claims are filed. Call the Claims Administrator for complete information.

The following travel expenses in connection with an approved human organ transplant performed at Centers of Medical Excellence (CME), or Blue Distinction Centers for Specialty Care (BDCSC) or UC Family Provider and only when the recipient or donor's home is more than 50 miles from the specific CME, BDCSC or UC Family Provider provided the expenses are approved by the Claims Administrator in advance:

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

For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered services for transportation and lodging include, but are not limited to:

1. Childcare,
2. Mileage within the medical transplant Facility city,
3. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator,
4. Frequent Flyer miles,
5. Coupons, Vouchers, or Travel tickets,
6. Prepayments or deposits,
7. Services for a condition that is not directly related, or a direct result, of the transplant,
8. Phone calls,
9. Laundry,
10. Postage,
11. Entertainment,
12. Travel costs for donor companion/caregiver,
13. Return visits for the donor for a treatment of an illness found during the evaluation, and
14. Meals.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Immunizations

Preventive immunizations provided by a Network Provider are covered under this Plan. Please see the "Preventive Care" in this Benefit Booklet for a list of preventive immunizations.

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

Inpatient Services

Inpatient Hospital Care

Covered services include acute care in a Hospital setting and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

1. Medical care visits.
2. Intensive medical care when your condition requires it.
3. Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
4. A personal bedside examination by a Physician when asked by your Physician. Benefits are not available for staff consultations required by Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals via phone.
5. Surgery and general anesthesia.
6. Newborn exam. A Physician other than the one who delivered the child must do the examination.
7. Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

LiveHealth Online Services

LiveHealth Online provides access to U.S. board-certified doctors 24/7/365 via phone or online video consults for urgent, non-Emergency medical assistance, including the ability to write prescriptions. LiveHealth Online provides behavioral health services as well. This service is available by registering and going to www.livehealthonline.com, or by calling 1-888-LiveHealth.

Maternity and Reproductive Health Services

Maternity

Covered Services include those services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility (does not include home birth) including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay to include circumcision of a covered male Dependent;
- Prenatal, postnatal, and related services; and
- Medically Necessary fetal screenings, which are genetic or chromosomal status of the fetus, as allowed.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to a Network Provider to have Covered Services covered at the Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and submits to the Claims Administrator. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note Regarding Maternity Admissions: Under federal law, the Plan may not limit benefits for any Hospital length for childbirth for the mother or newborn to less than forty-eight (48) hours following vaginal birth, or less than ninety-six (96) hours following a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, the Plan may not require a Provider get authorization before prescribing a length of stay which is not more than of forty-eight (48) hours for a vaginal birth or ninety-six (96) hours following a C section.

Contraceptive Benefits

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.

Contraceptive supplies prescribed by a physician for reasons other than contraceptive purposes for Medically Necessary treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

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.

Certain contraceptives are covered under the "Preventive Care" later in this section.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit. Sterilizations for men are covered under the "Sterilization Procedures for Men" benefit.

Abortion Services

Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, Precertification is not required. "Abortion" means a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

Covered services are not subject to Deductible, Copayment, and/or Coinsurance.

Fertility Preservation

Covered services for Medically Necessary fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility or gender affirming surgery. These medical treatments may include chemotherapy, hormone therapy, radiation, surgery or other medications that are determined to incur the risk of Infertility. Covered services under the Plan are as follows:

- Standard fertility preservation treatments and collection identified by appropriate professional societies such as the American Society of Reproductive Medicine or American Society of Clinical Oncology
- Embryo freezing and egg freezing: medications, Doctors' fees, anesthesia costs, infectious disease testing and laboratory procedures

- Sperm freezing
- Infectious disease lab testing for reproductive material storage
- Reproductive material storage for the duration of membership in the UC SHIP Plan only; storage expenses are no longer covered when the Member leaves
- Surgical procedures related to fertility preservation services*
- Radiation shielding
- Prescription drugs that are pertinent to fertility preservation services

If the services are authorized (See “Getting Approval for Benefits” for details), this Plan will provide Medically Necessary benefits in connection with fertility preservation. Provider may bill annually for preservation. Member will be responsible for payment and for submitting invoices to Anthem quarterly for reimbursement.

Precertification is required prior to seeking services.

Fertility Diagnostic Testing Services

Covered Services include diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to treat only the following underlying medical conditions that cause Infertility. Testing services are provided on the same basis, at the same cost shares, as any other medical condition.

Coverage for fertility diagnostic testing. UC SHIP will cover services related to fertility testing for students receiving the following diagnoses:

- Polycystic Ovarian Syndrome (PCOS)
- Endometriosis
- Pelvic inflammatory disease
- Presence of ovarian or fallopian cysts
- Other diagnosed hormonal imbalances that could affect fertility.

The covered benefits are limited to selected procedures. Below describes the performance of tests/procedures in an office setting:

- Follicle-Stimulating Hormone (FSH)
- Luteinizing Hormone (LH)
- Estradiol
- Progesterone
- Anti-Mullerian Hormone
- Prolactin
- Thyroid-Stimulating Hormone
- Hysterosalpingogram (HSG)
- Doxycycline
- Saline sonogram
- Semen analysis

Lactation Consultation

The Plan will pay services of an International Board-Certified Lactation Consultant (IBCLC), but will be limited to $200 maximum per visit. A lactation consultant is a specialist trained to focus on the needs and concerns of the breastfeeding mother-baby pair and to prevent, recognize and solve breastfeeding difficulties.

Medical Evacuation

For Members who are studying or traveling abroad or international students in the U.S. on a non-immigrant visa, benefits will be paid toward reimbursement of the expenses incurred transporting you back to your country of legal residence for medical care and treatment. The Plan will pay medical evacuation benefits if: (a) your illness commenced or injury occurred while you were covered by this Plan; (b) your Physician certifies in writing that you are medically stable and you require further care and treatment for your accident or illness; and (c) you have incurred expenses for your transportation back to your country of legal residence for your medical care and treatment that is not coordinated through GeoBlue. The total amount of benefit for medical evacuation is $50,000.

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

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

Mental Health and Substance Use Disorder Services

You must obtain Precertification for certain Mental Health and Substance Use Disorder services and for the treatment of autism spectrum disorders. (See "Autism Spectrum Disorders Services" in this section and the "Getting Approval for Benefits" section for details.)

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that the Plan must cover per state law. Inpatient benefits include the following
  - Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license,
  - Psychiatric observation for an acute psychiatric crisis,
  - Detoxification – medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling,
  - Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
    - Treatment in a crisis residential program:
      - Observation and assessment by a Physician weekly or more often,
      - Rehabilitation and therapy.
  - Transitional residential recovery services for substance use disorders (chemical dependency).

- **Outpatient Services** including the following:
  - Treatment in an outpatient department of a Hospital or outpatient Facility, such as Partial Hospitalization/Day Treatment Programs and Intensive Outpatient Programs,
  - Outpatient substance use disorder day treatment programs,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program.

- **Office Visits** including the following:
  - Individual and group mental health evaluation and treatment,
  - Individual and group chemical dependency counseling,
  - Services to monitor drug therapy,

  - Methadone maintenance treatment,
    Medical treatment for withdrawal symptoms, Behavioral health treatment for Autism Spectrum Disorders in an office setting.
- **Virtual Visits** as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.

- **Other Outpatient Services** including the following:
  - Partial Hospitalization Programs and Intensive Outpatient Programs,
  - Outpatient substance use disorder day treatment programs,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
  - Electroconvulsive therapy,
  - Behavioral health treatment for Autism Spectrum Disorders in an office setting.
  - Transcranial Magnetic Stimulation (TMS)

- **Behavioral health treatment for Autism Spectrum Disorders**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See "Autism Spectrum Disorders" later in this section for a description of additional services that are covered.

- **Nutrition and Counseling.** Services and supplies provided for Medically Necessary dietary and nutritional evaluations and counseling, and for the treatment of eating disorders. Behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa.

Examples of Providers from whom you can receive Covered Services include:
- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C),
- Any agency licensed by the state to give these services, when we have to cover them by law, or
- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the "Autism Spectrum Disorders" section below.

Nutrition and Counseling

Covered Services include services and supplies provided for Medically Necessary dietary and nutritional evaluations and counseling for the following conditions:

- Diabetes (See "Diabetes Equipment, Education, and Supplies" earlier in this section)
- Eating disorders
- Morbid obesity
- Adults who are obese or overweight and who also have additional cardiovascular disease risk factors
- Children and adolescents ages 6 through 19 who are obese
- Ulcerative colitis
- Crohn's disease
- Celiac disease
- Diverticulitis

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

Office Visits for medical care (including second surgical opinion) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that a Doctor and Primary Care Provider visits in the home are different than the "Home Health Care Services" benefit described earlier in this Benefit Booklet.

Retail Health Clinic Care for limited basic medical care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or nurse practitioners. Services are limited to routine care and the treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and the treatment of common illnesses for adults and children. You do not have to be an existing patient or to have an appointment to use a walk-in Doctor's Office.

Urgent Care as described in the "Emergency and Urgent Care Services" information earlier in this section.

Orthotics

Please see "Durable Medical Equipment (DME), Medical Devices and Supplies" earlier in this section.

Osteoporosis

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by the Claims Administrator.

Benefits include coverage of Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescribed Drugs including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services, and

- Therapy services.

Phenylketonuria (PKU)

Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Claims Administrator. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under your separate prescription drug benefit. For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

“Special food product” means a food product that is all of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
2. Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and
3. Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein but may include a food product that is specially formulated to have less than one gram of protein per serving.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use a Network Provider.

Certain benefits for Members who have current symptoms, or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. You may also refer to the following website for more information, https://www.uspreventiveservicestaskforce.org/uspstf/.

   Examples include screenings for:

a. Breast cancer,
b. Cervical cancer,
c. Colorectal cancer screenings, including a required colonoscopy following a positive result on a test or procedure, other than a colonoscopy,
d. High blood pressure,
e. Type 2 Diabetes Mellitus,
f. Cholesterol,
g. Child and adult obesity
h. Preexposure prophylaxis (PrEP) for prevention of HIV infection.

2. Preventive immunizations as follows:

a. Diphtheria/Tetanus/Pertussis, administered together or individually
b. Measles, Mumps and Rubella
c. Varicella
d. Influenza
e. Hepatitis A and Hepatitis B, administered together or individually
f. Pneumococcal
g. Meningococcal
h. Meningococcal B. The first injection in the series must be administered between the ages of 16 through 23.
i. Anthrax
j. BCG
k. DTaP
l. Hib
m. Hib and DTP
n. Japanese Encephalitis
o. MMRV
p. Rabies
q. Smallpox
r. Typhoid
s. Yellow Fever
t. Zoster
u. Polio
v. Human Papillomavirus [HPV] (female and male). The first injection in the series must be administered by age 26. Refer to the CDC link for recommendations over age 26: http://www.cdc.gov/vaccines/acip/index.html.

w. COVID-19

Please note that certain age and gender and quantity limitations apply.

3. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

4. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

5. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

a. All FDA-approved contraceptive drugs, devices and other products for women, including over-the-counter items, if prescribed by a Physician.

This includes contraceptive drugs as well as other contraceptive medications such as, injectable contraceptives and patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It

also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

Mobile apps for contraception based on fertility awareness are also covered. Member will be responsible for submitting invoices to Anthem for reimbursement.

Items and services that are integral to the furnishing of contraceptive services, including coverage for anesthesia for a tubal ligation procedure or pregnancy tests needed before provision of certain forms of contraceptives, such as an intrauterine device (also known as an IUD), regardless of whether the items and services are billed separately.

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

In order to be covered as Preventive Care, contraceptive Prescription Drugs must be either generic oral contraceptives or *brand name drugs*. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy." For additional information contact OptumRx at 1-844-265-1879 or www.optumrx.com.

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

c. Gestational diabetes screening.

d. Preventive prenatal care.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

7. Tuberculosis (TB) Screening as part of an annual preventive physical examination for Members. This service is available at no cost for student members only at the student health services on campus. Covered dependents may seek services off campus.

8. Titer laboratory tests to measure the level of antibodies for a specific disease. Immunization titers may be performed to determine if a *membe*r should have a vaccination.

9. Preventive care services for smoking cessation and tobacco cessation for Member's age 18 and older as recommended by the United States Preventive Services Task Force including counseling.

You may call UC SHIP Member Services at 1-866-940-8306 for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Prosthetics

Please see "Durable Medical Equipment (DME), Medical Devices and Supplies" earlier in this section.

Psycho-educational Testing

Psycho-educational testing will be covered when conducted by a neuropsychologist, or licensed clinical, educational, or counseling psychologist in order to assess and diagnose functional limitations due to learning disabilities. The Plan's maximum will not exceed $4,500 during the Member's lifetime while covered under UC SHIP.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Repatriation of Remains Expense

The Plan will pay expenses incurred to meet the minimum legal requirements up to the Maximum Amount of Coverage to prepare and transport your remains from the United States to the country of your permanent legal residence, or if you are a permanent legal resident of the United States from the country in which are traveling to the United States. This includes preparation and transportation of your human remains including:

- Embalming
- Local Cremation
- Minimally Necessary Casket for Transportation
- Air Transportation of your remains
- Any other expense to comply with local laws or regulations

Conditions for Benefits

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

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

Maximum Amount of Coverage $25,000

Exclusions

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

Not Covered. Services received before your Effective Date.

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

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

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

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

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified state laws as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the "Preventive Care" section in this Benefit Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

1) Accepted operative and cutting procedures;
2) Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
3) Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
4) Treatment of fractures and dislocations;
5) Anesthesia and surgical support when Medically Necessary;
6) Medically Necessary pre-operative and post-operative care.

Bariatric Surgery

Services and supplies in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a designated BDCSC facility or by a UC Family Provider.

Note: Precertification is required. Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a BDCSC or by a UC Family Provider will not be considered as covered under the Plan.

Bariatric Travel Expense

The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Member's home is fifty (50) miles or more from the nearest bariatric BDCSC or UC Family Provider. All travel expenses must be approved by the Claims Administrator in advance. The fifty (50) mile radius around the BDCSC or UC Family Provider will be determined by the bariatric BDCSC or UC Family Provider coverage area. (See "Definitions".)

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

Member Services will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric BDCSC or UC Family Provider. Details regarding reimbursement can be obtained by calling the Member Services 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.

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the Dental Services section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses

Reconstructive Surgery

Benefits include reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment to create a more normal appearance. Benefits include surgery performed to restore symmetry following mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits or follow-up care for a medically necessary mastectomy and who chooses breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Temporomandibular Joint Disorder (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore function, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services unless provided by a licensed physical therapist.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech language and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities daily living such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.
- **Acupuncture –** Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment consists of inserting needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents.

- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, and treatment planning.
- **Cognitive rehabilitation therapy** – Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Hemodialysis Treatment.** This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

  The following renal dialysis services are covered:

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

- **Infusion Therapy –** The following services and supplies when provided by an Infusion Therapy Provider in your home or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

  - 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;

  - Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

  - 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;

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

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

  - Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

    Please note: Only specified Network Providers have been approved by the Claims Administrator to provide medications to treat hemophilia. To find an approved Network Provider who can provide medications to treat hemophilia, please call the toll-free number 1-866-940-8306, if you have any questions about making this determination. Drugs to treat hemophilia, that you receive from a provider other than a Network Provider approved by the Claims Administrator, will be considered Out-of-Network provider charges subject to the cost shares and any limitations associated with those services.

  Infusion Therapy Provider services are subject to pre-service review to determine medical necessity. See “Getting Approval for Benefits” for details.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room.

Urgent health problems include earache, sore throat, and fever (not above 104 degrees). Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits (Telemedicine / Telehealth Visits)

Covered Services include virtual Telemedicine / Telehealth visits. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

"Telemedicine / Telehealth" means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging through our mobile app and interactive store and forward (asynchronous) technology, facsimile, audio-only telephone or electronic mail. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. Benefits for Telehealth are provided on the same basis and to the same extent as the same Covered Services provided through in-person contact. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Coverage under this section is not limited to services delivered to select third-party corporate telehealth providers.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

Benefits do not include the use of texting (outside of our mobile app, or website, electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, benefit precertification, or Provider to Provider discussions except as approved under "Office and Home Visits."

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

Vision Services

Note: Please see the Blue View Vision Insight Benefit Booklet for additional vision plan benefits available to you.

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses and contact lenses except as listed in the "Prosthetics" benefit.

Vision Services – Pediatric

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

Routine Eye Exam

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

Eyeglass Lenses

The following lens options are included at no extra cost when received from a Network Provider:

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

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

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

Frames

- Frames are limited to once every Benefit Year

Elective Contact Lenses

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

Non-Elective Contact Lenses

- Non-elective contacts may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Non-elective contact lenses are provided when Medically Necessary, including but not limited to the following conditions:

  – Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses, pathological myopia, aphakia, Anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism
  – High Ametropia exceeding -12D or +9D in spherical equivalent
  – Anisometropia of 3D or more
  – Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

  Note: If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the "Schedule of Benefits".

Low Vision

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

Low vision benefits include:

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

Timely Access to Vision Care

Anthem ensures that its contracted vision care provider networks have the capacity and availability to offer appointments within the following timeframes:

- Urgent Care appointments within seventy-two (72) hours of the request for an appointment;
- Non-urgent appointments for vision care: within thirty-six (36) business days of the request for an appointment;
- Preventive vision care appointments: within forty (40) business days of the request for an appointment
- After hours care (when a vision provider's office is closed): In Network vision Providers are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain urgent or Emergency Care including, when applicable, how to contact another vision provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or Emergency Care;
- Question for Anthem's customer service by telephone on how to get care or solve a problem: 10 minutes to reach a live person by phone during normal business hours.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section not meant to be a complete list of all the items that are excluded by your Plan.

1) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond the Claims Administrator's control, the Claims Administrator will make a good faith effort to give you Covered Services. The Claims Administrator will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience. This Exclusion does not apply to acts of terrorism.

2) **Administrative Charges**

   a) Charges for the completion of claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees charged for educational brochures or calling you to give you the test results.

3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

4) **Alpha Feto Protein Program** Participation in the Expanded Alpha Feto Protein Program, a statewide prenatal testing program administered by California's State Department of Health Services, is not covered.

5) **Alternative / Complementary Medicine** Services or supplies related to alternative or complementary medicine. This includes, but is not limited to:

   a. Holistic medicine,
   b. Homeopathic medicine,
   c. Hypnosis,
   d. Aroma therapy,
   e. Massage and massage therapy,
   f. Reiki therapy,
   g. Herbal, vitamin or dietary products or therapies,
   h. Naturopathy,
   i. Thermography,
   j. Orthomolecular therapy,
   k. Contact reflex analysis,
   l. Bioenergetic synchronization technique (BEST),
   m. Iridology-study of the iris,
   n. Auditory integration therapy (AIT),
   o. Colonic irrigation,
   p. Magnetic innervation therapy,
   q. Electromagnetic therapy,
   r. Neurofeedback / Biofeedback

6) **Autopsies.** Autopsies and post-mortem testing

7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

8) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Benefit Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

9) **Charges over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the back of this Booklet.

10) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

11) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.

12) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This exclusion does not apply to any services and supplies that are covered as part of Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, services provided for the treatment of Gender Dysphoria, or any surgery to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomology or creating a normal appearance.

13) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

14) **Couples Therapy** Marriage counseling, also known as couples counseling or couples therapy, strictly for relationship counseling.

15) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments

16) **Crime** Treatment of injury or illness that results from a crime you committed or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were a victim of a crime, including domestic violence.

17) **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 "What's Covered" section. Services provided by a rest home, a home for the aged, a nursing home or any similar Facility.

18) **Dental Devices for Snoring** Oral appliances for snoring.

19) **Dental Treatment (for age 19 and over)** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as;

    - removing, restoration, and replacement of teeth;
    - medical care or surgery for dental problems (unless listed as a Covered Service in this Benefit Booklet);
    - services to help dental clinical outcomes; or
    - Orthodontic services.

This Exclusion does not apply to the services that must be covered by law.

20) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to the Medically Necessary treatment of autism spectrum disorders, to the extent stated in the "Autism Spectrum Disorders Services" section under "What's Covered.".

21) **Emergency Room Services for non-Emergency Care** Services provided in an Emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an Emergency room.

22) **Experimental / Investigative Services** Supplies or services that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental / Investigative.

23) **Eyeglasses and Contact Lenses (for age 19 and over)** Eyeglasses and contact lenses to correct your eyesight. This Exclusion does not apply to lenses needed after a covered eye surgery.

24) **Eye Exercises** Orthoptics and vision therapy.

25) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy, except as listed in this Benefit Booklet.

26) **Family Members** Services prescribed, ordered, referred by or given by a member of your family, including your spouse, child, brother, sister, parent, in-law, or self.

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

28) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removal of corns and calluses; trimming nails; hygienic and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

29) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under Durable Medical Equipment (DME), Medical Devices and Supplies.

30) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

31) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

32) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services received during a jail or prison sentence, services you get from Workers Compensation benefits, and services from free clinics.

If Worker's Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

33) **Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth

34) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This Exclusion also applies to health spas.

35) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

36) **Home Births** – Maternity care for childbirth services provided in the home. Maternity care delivery is a Covered Service only when provided in a Facility as part of the "Maternity" benefit.

37) **Home Health Care**

    a) Services given by registered nurses and other health workers who are not employees or under approved arrangements with a home health care Provider.

    b) Food, housing, homemaker services and home delivered meals.

38) **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.

39) **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.

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

41) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.

42) **Medical Equipment, Devices and Supplies**

    a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

    b) Surgical supports, corsets, or articles of clothing unless for the purpose of recovering from surgery or injury.

    c) Non-Medically Necessary enhancements to standard equipment and devices.

    d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

    e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

43) **Medicare** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

44) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

45) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

46) **Non-Licensed Providers** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by the Claims Administrator. This Exclusion does not apply to the Medically Necessary treatment of autism spectrum disorders, to the extent stated in the "Autism Spectrum Disorders Services" section.

47) **Non-Medically Necessary Services** Services the Claims Administrator concludes are not Medically Necessary This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

48) **Not Specifically Listed** Services not specifically listed in this Plan as Covered Services. Some services not specifically listed may be covered under the Plan. Please call the member service telephone number at 1-866-940-8306.

49) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that you can buy over-the-counter and those you can get without a written prescription or from a licensed pharmacist.

50) **Off label use** Off label use, unless the Plan must cover it by law or if the Claims Administrator approves it.

51) **Oral Surgery (for ages 19 and over)** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.

52) **Outpatient Prescription Drugs and Medications** Outpatient prescription drugs or medications and insulin, except as specifically stated under the Home Infusion Therapy and Therapeutic/Elective Abortion provisions of "What's Covered" section. Male condoms and Women's related preventive services that are considered pharmacy, please refer to your pharmacy benefits plan booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids. See your pharmacy benefits plan booklet for information on outpatient prescription drugs, medication and insulin. However, health aids that are Medically Necessary and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment (DME), Medical Devices and Supplies" provision of "What's Covered" section, are covered, subject to all terms of this Plan that apply to that benefit.

53) **Personal Care, Convenience and Mobile/Wearable Devices**

   a) Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

   b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

   c) Home workout or therapy equipment, including treadmills and home gyms,

   d) Pools, whirlpools, spas, or hydrotherapy equipment,

   e) Hypo-allergenic pillows, mattresses, or waterbeds, or

f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

54) **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.

55) **Private Duty Nursing** Private Duty Nursing Services except as listed in this Benefit Booklet.

56) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.

57) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

b) Care provided or billed by a lodging, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

58) **Routine Physicals and Immunizations** Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the "Preventive Care" benefit. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law, or to immunizations required or recommended for travel to countries outside the United States.

59) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.

60) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

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

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

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

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

62) **Special Footwear** Footwear that is needed by persons who suffer from foot disfigurement.

63) **Stand-By Charges** Stand-by charges of a Physician or other Provider.

64) **Sterilization** Services to reverse an elective sterilization.

65) **Surrogate Mother Services** Supplies and services for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

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

67) **Telephone and Facsimile Machine Consultations** Consultations provided by telephone or facsimile machine, except as specifically provided under the Telehealth provision of “What’s Covered” section

68) **Travel Costs** Mileage, lodging, meals and other Member-related travel costs except as described in this Plan for bariatric, transplant or gender affirming surgeries.

69) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

70) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

71) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.

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

    This Exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.

72) **Wilderness.** Wilderness or other outdoor camps and/or programs. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

73) **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.

Claims Payment

This section describes how the Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from a Network Provider, you do not need to file a claim because the Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Physicians and other Providers will still submit your claim for you, although they are not required to do so. If you submit the claim, use a claim form as described later in this section.

Maximum Allowed Amount

GENERAL

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see **"Inter-Plan Arrangements"** section for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement this Plan will allow for services and supplies:

- That meet the definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Except for Surprise Billing Claims*, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

*Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the back of this Booklet. Please refer to that section for further details.

When you receive Covered Services from an eligible Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Maximum Allowed Amounts may be reduced for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific Plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit www.anthem.com/ca.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

Except for Surprise Billing Claims, the Maximum Allowed Amount for Covered Services you receive from an Out-of-Network Provider, Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator Out-of-network fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this product but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount or if your claim involves a Surprise Billing Claims.

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing that would be used if the healthcare services had been obtained within the Anthem Services Area, or a special negotiated price.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount unless your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding a Network Provider or visit www.anthem.com/ca.

Member Services is also available to assist you in determining this/your Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

MEMBER COST SHARE

For certain Covered Services, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance). **The Member is responsible for costs in excess of the Maximum Allowed Amount.**

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for your cost share responsibilities and limitations or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Claims Administrator will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your policy and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your lifetime maximum, benefit caps or day/visit limits.

Example:

- *You choose a Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; your Coinsurance responsibility when a Network surgeon is used is 15% of $1500, or $225. The Claims Administrator pays 85% of $1500, or $1275. The Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $225.*

- *You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; your Coinsurance responsibility for the Out-of-Network surgeon is 40% of $1500, or $600 after the Out-of-Network Deductible has been met. The Claims Administrator pays the remaining 60% of $1500, or $900. In addition, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total out of pocket charge would be $600 plus an additional $1000, for a total of $1600.*

AUTHORIZED SERVICES

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Claims Administrator may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. The Claims Administrator also may authorize the Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Claims Administrator authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Network Provider for that specialty in your state of residence. You contact the Claims Administrator in advance of receiving any Covered Services, and they authorize you to go to an available Out-of-Network Provider for that Covered Service and they agree that the Network cost share will apply.

Your Plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for Network Providers of participating providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because the Claims Administrator has authorized the Network cost share amount to apply in this situation, you will be responsible for the Network Copayment of $25 and the Claims Administrator will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Network Copayment of $25, your total out of pocket expense would be $325.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, the Claims Administrator must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information the Claims Administrator needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. To obtain a claim form you may call Member Services at 1-866-940-8306 or go to Anthem's website at www.anthem.com/ca. If you do not receive the claim form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

  - Name of patient.
  - Patient's relationship with the Subscriber.
  - Identification number.
  - Date, type, and place of service.
  - Your signature and the Provider's signature.

  Out-of-Network claims must be submitted within 12 months after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 12-month period. The claim must have the information the Plan needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask you for more details and inform you of the time by which the Plan needs to receive that information. Once the Claims Administrator receives the required information, the Claims Administrator will process the claim according to the terms of your Plan.

  Claims submitted by a public (government operated) Hospital or clinic will be paid by the Claims Administrator directly, as long as you have not already received benefits under that claim. The Claims Administrator will pay all claims within 30 days after receiving proof of loss. If you are dissatisfied with the Claims Administrator's denial or amount of payment, you may request that the Claims Administrator review the claim a second time, and you may submit any additional relevant information.

  Out of Country claims – Please refer to the **BCBS Global Core® Program section regarding out of country claims submission.**

  Please note that failure to submit the information the Claims Administrator needs by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to the Claims Administrator all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. If you fail to cooperate you will be responsible for any charge for services.

Payment of Benefits

The Claims Administrator may make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, the Claims Administrator may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a student who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Plan), or that person's custodial parent or designated representative. Any benefit payments made will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by any applicable state law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill their contractual obligations. But the Host Blue is responsible for: (a) contracting with its Provider; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims as noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, Anthem will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside The Service Area

The pricing method used for non-participating provider claims incurred outside the Anthem Service Area is described in "Claims Payment".

E. BCBS Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your BCBS Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with you.

When you are traveling abroad and need medical care, you can call the BCBS Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need Inpatient Hospital care, you or someone on your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting Approval for Benefits” section in this Benefit Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the Hospital for Emergency or non-Emergency care.

How Claims are Paid with BCBS Global Core®

In most cases, when you arrange Inpatient Hospital care with BCBS Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctor services;
- Inpatient Hospital care not arranged through BCBS Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BCBS Global Core®claim forms you can get international claims forms in the following ways:

- Call the BCBS Global Core® Service Center at the number above; or
- Online at www.bcbsglobalcore.com

You will find the address for mailing the claim on the form.

Note about UC Travel Insurance: The UC Office of the President purchases a travel accident policy for students traveling to foreign countries to participate in University sponsored academic programs, University research projects or other University related purposes at no additional cost to the students. For more information about this benefit and to register for the program, please go to:

https://www.ucop.edu/risk-services-travel/index.html

This insurance provides emergency medical assistance, as well as many other benefits. To ensure you receive access to the full spectrum of benefits, it is highly recommended that you register your travel at the website listed above prior to your trip. Registration is simple and takes less than 5 minutes.

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

Coordination of Benefits When Members Are Insured Under More Than One Plan

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

If you are covered by more than one 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 Plan Year. Any coverage you have for medical or pediatric dental benefits, will be coordinated as shown below.

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not an Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise the Claims Administrator that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.
5. National Collegiate Athletic Association (NCAA) or the National Association of Intercollegiate Athletics (NAIA)

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

This provision will apply in determining a person's benefits under This Plan for any Calendar Year if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that Calendar Year.

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 Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

The first of the following rules which applies will determine the order in which benefits are payable:

1. A member is treated at the Student Health Center. UC SHIP is primary for these services. You may have to submit your receipt to your other health plan for reimbursement.
2. 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.

   Note: This Plan is secondary coverage to all other policies except Medi-Cal, MRMIP, and TRICARE.
3. In most cases, a plan which covers you as a Member pays before a plan which covers you as a dependent. However, UC SHIP is secondary to all other plans except Medi-Cal, MRMIP, and TRICARE. Another exception is 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 employee.

THE CLAIMS ADMINISTRATOR'S RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. The Claims Administrator is 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, the Claims Administrator has the right to pay that Other Plan any amount they 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 the Claims Administrator's 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, the Claims Administrator has 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.

Subrogation and Reimbursement

These Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained, and You have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, “You” or “Your” includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former plan participants and plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person’s relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers’ compensation insurance or fund, premises medical payments coverage, restitution, or “no-fault” or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of Your recovery. If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by You to the

contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Assignment

In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a

Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or

2. You fail to cooperate.

In the event You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in its entirety and reserves the right to make changes as it deems necessary.

Termination and Continuation of Coverage

Termination of Coverage

For students, coverage ends as provided below:

1. If the Plan terminates, the student's coverage ends at the same time. This Plan may be canceled or changed at any time without notice. If the Plan terminates or changes, an Insured student will remain covered for claims incurred but not filed or paid prior to Plan termination or change.
2. If the Plan no longer provides coverage for the class of students to which an Insured student belongs, the student's coverage ends on the Effective Date of that change.
3. If the student graduates from the University, the student's coverage continues through the last day of the Coverage Period during which the student graduates from the University.
4. If the student withdraws or is dismissed from the University, whether or not coverage will be continued after the date of the withdrawal or dismissal will be determined by campus policy. Contact the student health insurance office for more information.
5. Enrollment in the Plan may be terminated for the reasons listed below. The student shall be notified in writing of the termination. Termination shall be effective no less than 30 days following the date of the written notice.

   a. In regard to eligibility for UC SHIP, you knowingly provide material information that is false, or misrepresents information on any document or fail to notify the Plan Administrator of changes in your or your Dependents' status.

   b. You knowingly permit the use of your Plan Identification Card by someone other than yourself or your Dependents to obtain services; or

   c. You knowingly obtain or attempt to obtain services under the Plan by means of false, materially misleading, or fraudulent information, acts or omissions.

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

   The Director of UC SHIP is responsible for the final decision on termination of enrollment in the Plan.
6. If a registered student has been terminated from the Plan and has no major medical health insurance coverage, as required by the Regents of the University of California, the student health services staff will provide the student with assistance to find a health insurance plan that meets the University's minimum health benefit standards. Students may also contact www.coveredca.com to review Covered California exchange plans. The student is wholly responsible for the cost of any plan in which he or she enrolls, and any medical care not covered under that plan, including costs of applying for coverage and plan premiums.

Coverage end for Dependents, whichever occurs first.

1. When the student's coverage ends,
2. When the Dependent no longer meets the dependent eligibility requirements,
3. At the end of each Coverage Period (unless a new enrollment form has been submitted for the next coverage.

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

You may be entitled to continued benefits under terms which are specified elsewhere under "Continuation of Benefits after Termination".

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

If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Claims Administrator for the Maximum Allowed Amount for services received through such misuse.

Should you or any family Members be receiving covered care in the Hospital at the time your membership terminates for reasons other than your UC SHIP's cancellation of this Plan, or failure to pay the required premiums, benefits for Hospital Inpatient care will be provided until the date you are discharged from the Hospital or 30 days, whichever comes first.

CONTINUATION OF BENEFITS AFTER TERMINATION

If a Member is confined as an Inpatient in a Hospital on the date of termination of the Plan or when coverage would otherwise terminate, benefits may be continued for treatment of illness or injury for which the Member is hospitalized. No benefits are provided for services treating any other illness, injury, or condition. The Member's benefits will be extended for a period of 30 days provided that the Member is confined as an Inpatient in a Hospital, under a Physician's care, and the services are Medically Necessary. Any benefits payable under this Plan will not exceed any benefit maximums shown under the section entitled "Schedule of Benefits".

General Provisions

Care Coordination

The Claims Administrator pays Network Providers in various ways to provide Covered Services to you. For example, sometimes they may pay Network Providers a separate amount for each Covered Service they provide. The Claims Administrator may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Claims Administrator may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Claims Administrator may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Claims Administrator because they did not meet certain standards. You do not share in any payments made by Network Providers to the Claims Administrator under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan or the Claims Administrator.

Confidentiality and Release of Information

Applicable state and federal law requires the Claims Administrator to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing the Claims Administrator's policies and procedures regarding the protection, use and disclosure of your medical information is available on the Claims Administrator's website and can be furnished to you upon request by contacting the Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Confidential Communications

If you are an adult covered by the Student's health plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law, you may request confidential communication, either in writing or electronically. You may also call us at the phone number on the back of the ID card.

The confidential communication request will apply to all communications that disclose medical information or a Provider's name and address related to the medical services received by the individual requesting the confidential communication.

A confidential communication request will be valid until we receive from you either a revocation of the request, or a new confidential communication request.

Anthem will implement the confidential communication within 7 calendar days of receiving an electronic request or by phone, or 14 calendar days from the date we receive a written request. We will also acknowledge that we received the request and will provide status if you contact us.

Conformity with Law

Any term of the Plan which is in conflict with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Form or Content of Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan Administrator.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payer. If duplication of such benefits occurs, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

Legal Actions

No attempt to recover on the Plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this Plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent the Plan has made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem Blue Cross and Blue Shield has adopted a Members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to www.anthem.com/ca and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the UC SHIP, or by mutual agreement at the time of renewal between the Claims Administrator and the UC SHIP without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

The Claims Administrator is not responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Plan Administrator based on the actions of a Provider of health care, services, or supplies.

Payment of Benefits

You authorize the Claims Administrator to make payments directly to Providers for Covered Services. In no event, however, shall the Claims Administrator's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator reserves the right to make payments directly to you as opposed to any Provider for Covered Service, at the Claims Administrator's discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or you) will discharge the Claims Administrator's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request for us to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents. Any assignment made without written consent from the Plan will be void and unenforceable.

Policies, Procedures, and Pilot Programs

The Claims Administrator are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, we have the authority, in our discretion, to institute from time to time, pilot or test programs for utilization management, care management, case management, clinical quality**,** disease management or wellness initiatives in certain designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Group's Health Plan, unless otherwise agreed to by the Group. We reserve the right to discontinue a pilot initiative at any time without advance notice to Group.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Group's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As the Claims Administrator of your Group's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the Member Services number on the back of your Identification Card.

Protecting Your Privacy

Where to find our Notice of Privacy Practices.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:
For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your Plan.

For health care operations: We use and share PHI for health care operations.
For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your Doctor or a hospital. Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the Member of your Plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

- We may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit https://www.anthem.com/ca/privacy for more information.

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of our Notice of Privacy Practices on our website at https://www.anthem.com/ca/privacy or you may contact Member Services at 1-866-940-8306.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Plan may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Plan has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery and adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or under payment amount. The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount paid for the Covered Services.

Worker’s Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Worker’s Compensation Law. All money paid or owed by Worker’s Compensation for services provided to you shall be paid back by, or on your behalf to the Plan if it has made payment for the services received. It is understood that coverage under this Plan does not replace or affect any Worker’s Compensation coverage requirements.

Definitions

If a word or phrase in this Benefit Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at 1-866-940-8306.

Accidental Injury

An unexpected injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between the Claims Administrator and the Plan Administrator regarding the administration of certain elements of the health care benefits of the Plan Administrator's Group Health Plan.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that satisfies our accreditation requirements and is approved by the Claims Administrator.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that the Claims Administrator has agreed to cover at the Network level. You will have to pay any Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Balance Billing

A Provider bills you for the difference between the amount they charge and the amount that the Plan will pay.

Bariatric BDCSC Coverage Area

The area within the 50-mile radius surrounding a designated bariatric BDCSC or UC Family Provider.

Benefit Booklet

This document. The Benefit Booklet provides you with a description of your benefits while you are enrolled under the Plan.

Benefit Year

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

Benefit Year Maximum

The maximum amount that the Plan will pay for specific Covered Services during a Benefit Year.

Blue Distinction Centers for Specialty Care (BDCSC)

Health care providers designated by the Claims Administrator as a selected facility for specified medical services. A Provider participating in a BDCSC network has an agreement in effect with the Claims Administrator at the time services are rendered or is available through their affiliate companies or our

relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the Maximum Allowed Amount as payment in full for Covered Services.

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

Centers of Medical Excellence (CME)

Health care providers designated by the Claims Administrator as a selected facility for specified medical services. A Provider participating in a CME network has an agreement in effect with the Claims Administrator at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the Maximum Allowed Amount as payment in full for Covered Services.

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

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Blue Cross Life and Health ("Anthem") was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Consolidated Appropriations Act of 2021

Please refer to the “Consolidated Appropriations Act of 2021 Notice” on page 143 of this Booklet for details.

Contracting Hospital

A Hospital which has a Standard Hospital Contract in effect with the Claims Administrator to provide care to Members. A Contracting Hospital is not necessarily a Network Provider. A list of contracting hospitals will be sent on request.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the “Schedule of Benefits” or the amount the Provider charges.

Coverage Period

The period during which a student and his or her covered Dependents are eligible for coverage and receive the benefits of this Plan.

Covered Services

Health care services, supplies, or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if precertification is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the "Termination and Continuation of Coverage" section.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please refer to the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

1. Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
2. Changing dressings of non-infected wounds, after surgery or chronic conditions,
3. Preparing meals and/or special diets,
4. Feeding by utensil, tube, or gastrostomy,
5. Common skin and nail care,
6. Supervising medicine that you can take yourself,
7. Catheter care, general colostomy or ileostomy care,
8. Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
9. Residential care and adult day care,
10. Protective and supportive care, including education,
11. Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $200, your Plan won't cover anything until you meet the $200 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A Member of the student's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Doctor

See the definition of "Physician."

Domestic Partner (Domestic Partnership)

A Member of the student's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

- Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which we determine in its sole discretion to be experimental or investigational. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

  The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

  - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
  - Has been determined by the FDA to be contraindicated for the specific use.
  - Is provided as part of a clinical research protocol or clinical trial (except where coverage for such trial is mandated by applicable law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product,

equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.

- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

- Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by us. In determining whether a service is experimental or investigational, we will consider the information described in subsection (c) and assess all of the following:
  - Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
  - Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
  - Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- The information we consider or evaluate to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:
  - Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal.
  - Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
  - Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
  - Documents of an IRB or other similar body performing substantially the same function.
  - Consent documentation(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
  - The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
  - Medical records.
  - The opinions of consulting providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

Explanation of Benefits (EOB)

Is a statement describing Is a statement describing the costs and services for care and is generated when a provider submits a claim. Explanation of Benefits are mailed but you have the right to opt for your communications to be sent electronically. Once you register on the Sydney Health mobile app or on our website www.anthem.com/ca the option is available under communications.

Facility

A facility is a place where healthcare services may be provided including but not limited to, a Hospital, Freestanding Ambulatory Surgical Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health facility, as defined in this Benefit Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by the Claims Administrator.

Formulary

A specified list of covered materials.

Health Plan or Plan

A Student welfare benefit plan established by the Plan Administrator, in effect as of the Effective Date.

Home Health Care Agency

A Provider, licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that satisfies our accreditation requirements and is approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Identification Card (ID Card)

The latest card (electronic or paper) given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective. You can download your electronic ID card by downloading the Sydney Mobile health app or signing in through Anthem's website www.anthem.com/ca.

Infertility

Consists of the following: (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.

Infusion Therapy

The administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Benefit Booklet, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Insured student

A registered person who, by meeting the Plan's eligibility requirements for an eligible student, is enrolled under this Plan. The student may elect coverage for his or her eligible dependents. Such requirements are outlined in Eligibility and Enrollment – Adding Members". The student is also called the Member.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Investigational Procedures (Investigational)

- have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or
- do not have final approval from the appropriate governmental regulatory body; or
- are not supported by scientific evidence which permits conclusions concerning the effect of the service, Drug, or device on health outcomes; or
- do not improve the health outcome of the patient treated; or
- are not as beneficial as any established alternative; or
- are those whose results outside the Investigational setting cannot be demonstrated or duplicated; or
- are not generally approved or used by Physicians in the medical community.

Anthem has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a Covered Service because it is Investigational, the Member may request an Independent Medical Review. Please refer to the Part entitled "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES."

Late Enrollees

Employees or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maximum Allowed Amount

The maximum that the Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

The Claims Administrator reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Doctor has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. The Claims Administrator considers a service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Doctor, health care provider or Hospital;
- not primarily Custodial Care;
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis; and
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

Member

People, including the student and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Use Disorder

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition.

Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements.

Network Transplant Provider

Please refer to the "What's Covered" section for details.

Non-Contracting Hospital

A Hospital which does not have a Standard Hospital Contract in effect with the Claims Administrator at the time services are rendered.

Out-of-Network Provider

A Provider that does not have an agreement or contract with the Claims, or the Claims Administrator's subcontractor(s), to give services to Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please refer to the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Year for Covered Services. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the UC SHIP's health benefits.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is The Regents of the University of California.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is The Regents of the University of California.***

Plan Year

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

Precertification

Please see the section "Getting Approval for Benefits" for details.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, satisfies our accreditation requirements and, for In-Network Providers and is approved by us. Details on our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says must be covered under the Plan when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Referral

Please see the "How Your Plan Works" section for details.

Residential Treatment Center / Facility

An Inpatient Facility that treats Mental Health or Substance Use Disorder conditions. The Facility must be licensed as a treatment center pursuant to state and local laws. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physician Assistants and nurse practitioners.

Service Area

The geographical area where you can get Covered Services from a Network Provider and the Claims Administrator is approved to arrange healthcare services consistent with network adequacy requirements.

Skilled Nursing Facility

A facility licensed as a skilled nursing facility in the state in which it is located that satisfies our accreditation requirements and is approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Spouse

A Member of the student's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Surprise Billing Claim

Please refer to the "Consolidated Appropriations Act of 2021 Notice" of this Booklet for details.

Telehealth

"Telehealth" is the mode of providing health care or other health services using information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of the patient's health care. Benefits for Telehealth are provided to the same extent as the same Covered Services provided through in-person contact. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include consultations between the patient and the

health care Provider, or between health care Providers, by telephone, facsimile machine, or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Services at 1-866-940-8306.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

University of California Student Health Insurance Plan (UC SHIP)

The person or entity who has allowed its students to participate in the Plan by acting as the Plan Sponsor.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, procedures, and/or facilities.

Additional Benefit Services

After-Hours Nurse Advice

For after-hours nurse advice when student health services is closed, members can call student health at 1-831-459-2591 and be prompted to select the option to transfer to the nurse advice service. Students, voluntary non-registered students, and Dependents covered under UC SHIP have the option to call 24/7 NurseLine, see information below.

24/7 NurseLine

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

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

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

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

Future Moms

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

LiveHealth Online Services

LiveHealth Online provides access to U.S. board-certified doctors 24/7/365 via phone or online video consults for urgent, non-Emergency medical assistance, including the ability to write prescriptions. LiveHealth Online provides behavioral health services as well. This service is available by registering and going to www.livehealthonline.com, or by calling 1-888-LiveHealth. If follow up care is required after a consult, the student must obtain a referral from the SHS prior to seeking care outside of the SHS.

How to Get Language Assistance

Anthem Blue Cross Life and Health Insurance Company (Anthem) is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Care provided by Out-of-Network Providers; and
- Out-of-Network Air Ambulance Services.

Note: Covered Services provided by an Out-of-Network Provider at an In-Network Facility are also subject to the No Surprises Act under federal law, however these services are also subject to applicable CA state law. As a result, benefits under this Plan for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be subject to applicable CA state law. Please see the "Claims Payment" section for those details.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Out-of-Network Air Ambulance Services

If a member receives air ambulance services from an Out-of-Network Provider:

1. The Member will have the same cost share as an In-Network Provider;
2. The Member's cost shares will be applied toward any In-Network Provider Out-of-Pocket Maximum; and
3. Anthem will make an initial payment or deny the claim no later than 30 days after receiving the claim.

Balance billing is generally prohibited when you receive air ambulance services from an Out-of-Network Provider.

How Cost-Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Care or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Your Right To Appeals" section of this Benefit Book.

Provider Directories

The Claims Administrator is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from The Claims Administrator that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

The Claims Administrator provides the following information on its website:

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and federal agencies if you believe a Provider has violated the No Surprises Act.

You may also obtain the following information on The Claims Administrator's website or by calling Member Services at the phone number on the back of your ID Card:

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

In addition, the Claims Administrator will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

Federal Notices

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need precertification from the Claims Administrator or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact 1-866-940-8306 or refer to our website, www.anthem.com.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the plan. Also, a plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance, and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

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 contact AHP at 1-855-427-3175 or by email to ucship@ahpservice.com to enroll your child as your dependent.

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call Member Services at 1-866-940-8306.

Notices Required by State Law

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 Dependent 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 Doctor, Medical Group, independent practice association, or clinic, or call Member Services toll free at the telephone number on the back of your Identification Card to ensure that you can obtain the health care services that you need.

Notice of Non-Discrimination

The Claims Administrator does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For information on how to file a complaint, please see "Grievance And External Review Procedures." To file a discrimination complaint, please see "Getting Help In Your Language" at the end of this Booklet.

Confidential Communications of Medical Information

Any Member, including an adult or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law, may request confidential communication, either in writing or electronically. A request for confidential communication can be sent in writing to the Claims Administrator, P.O. Box 60007, Los Angeles, CA 90060-0007. An electronic request can be made by following steps at the Claims Administrator's website, www.anthem.com. You may also call Member Services at the phone number on the back of your Identification Card for more details.

The confidential communication request will apply to all communications that disclose medical information or a Provider's name and address related to the medical services received by the individual requesting the confidential communication.

A confidential communication request will be valid until either a revocation of the request is received from the Member who initially requested the confidential communication, or a new confidential communication request is received.

The Claims Administrator will implement the confidential communication request within seven (7) calendar days of receiving an electronic request or a request by phone, or within fourteen (14) calendar days from the date we receive a written request by first-class mail. We will also acknowledge that we received the request and will provide status if the Member contacts us.

Telehealth Provider Visits

Seeing a Provider by phone or video is a convenient way to get the care you need. The Claims Administrator contracts with telehealth companies to give you access to this kind of care. Telehealth coverage is not limited to these companies and includes services appropriately delivered through telehealth from other Providers on the same basis and to the same extent as in-person services. We want to make sure you know how your health benefits work when you see one of these Providers:

- Your Plan covers the telehealth visit just like an office visit with a Provider.
- Any out-of-pocket costs you have from the telehealth visit count toward your Plan's Deductible and Out-of-Pocket Limit, just like any other care you receive.
- You have a right to review the medical records from your telehealth visit.
- If we have the necessary information, your medical records from your telehealth visit will be shared with your current established Primary Care Provider as permitted by state and federal law, unless you tell us not to share them.

Our top priority is making sure you can get the healthcare you need, when you need it. If you have questions about how your Plan covers telehealth visits, log in to the Claims Administrator's website, www.anthem.com, to view your benefits. Or call us at the Member Services number on your ID Card.

Notice of Eligibility for Other Coverage

California requires residents and their dependents to obtain, and maintain, health coverage or pay a penalty, unless they qualify for an exemption. Enrolling in student health insurance offered by the college or university you are attending is one way to meet this requirement.

You may be eligible to get free or low-cost health coverage through Medi-Cal regardless of immigration status. In addition, you may be eligible for free or low-cost health coverage through Covered California. Visit Covered California at www.coveredca.com to learn about health coverage options that are available for you and your dependents, and how you might qualify to get financial assistance with the cost of coverage.

If you are under 26 years of age, you may be eligible for coverage as a dependent in a group health plan of your parent's employer or under your parents' individual market coverage. In addition, you may be eligible to buy individual health insurance directly from a health insurer or health plan, regardless of immigration status.

Please examine your options carefully to see if other options are more affordable and whether you are currently eligible to enroll in these other forms of coverage pursuant to an open or special enrollment period.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved with the Plan's grievance procedures. Grievances may be made by telephone (please call 1-866-940-8306 or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21215 Burbank Boulevard, Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your Identification Card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the Plan will be acknowledged in writing, together with a description of how the Plan proposes to resolve the grievance.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਤੁਹਾਡਾ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਦਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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