Benefit Booklet

University of California
HealthSavings+
Group Number: W3000984-M0048286 & M0048287
Effective Date: January 1, 2027

blue california

Blue Shield of California is an independent member of the Blue Shield Association

Claims Administered by Blue Shield of California

Table of contents

Table of contents **2**
Summary of Benefits **4**
Introduction **16**
About this Benefit Booklet 16
About this Plan 17
How to contact Customer Service 17
How to access care **19**
Health care professionals and facilities 19
Your Primary Care Physician 20
ID cards 21
Canceling appointments 21
Continuity of Care 21
Second medical opinion 22
Care outside of California 23
Emergency Services 23
If you cannot find an In-Network Provider – Gap Exception Process 23
Other ways to access care 24
Health advice and education 24
Utilization Management Program **26**
Prior authorization 26
While you are in the Hospital (inpatient utilization review) 28
After you leave the Hospital (discharge planning) 28
Using your Benefits effectively 28
Your payment information **30**
Paying for coverage 30
Paying for Covered Services 30
Claims 34
Your coverage **36**
Eligibility for this Plan 36
Plan changes 36
Coordination of benefits 36
When coverage ends 37
Your Benefits **39**
Acupuncture services 39
Allergy testing and immunotherapy Benefits 39
Ambulance services 40
Bariatric surgery Benefits 40
Blue Cross Blue Shield Global® Core Program 40
Breast Health Screening services (Athena) 41
Chiropractic services 41
Clinical trials for treatment of cancer or life-threatening diseases or conditions Benefits 41
Diabetes care services 43
Diagnostic X-ray, imaging, pathology, laboratory, and other testing services 43
Dialysis Benefits 44

Durable medical equipment 44
Emergency Benefits 46
Family planning and Infertility Benefits 47
Fertility preservation services 48
Gender affirmation services 48
Hearing Aid Services 49
Home health services 49
Hospice program services 51
Hospital services 52
Medical treatment of the teeth, gums, jaw joints, and jaw bones 53
Mental Health and Substance Use Disorder Benefits 54
Physician and other professional services 56
PKU formulas and special food products 57
Podiatric services 57
Pregnancy and maternity care 57
Preventive Health Services 58
Reconstructive Surgery Benefits 59
Rehabilitative and habilitative services 60
Skilled Nursing Facility (SNF) services 61
Transplant services 61
Travel expense reimbursement for bariatric, gender affirmation and transplant services 62
Urgent care services 63
Exclusions and limitations 64
Settlement of Disputes 69
Other important information about your Plan 72
Your coverage, continued 72
Special enrollment period 72
Out-of-area services 73
Limitation for duplicate coverage 77
Exception for other coverage 77
Reductions – third-party liability/Subrogation 77
Coordination of benefits, continued 79
General provisions 83
Definitions 85
Notices about your Plan 99
Notice informing individuals about nondiscrimination and accessibility requirements 104
Language access services 105
Family Building Plan Design- Cycle Lifetime Benefit 106

blue california

Summary of Benefits

University of California
Effective January 1, 2027
PPO Savings Plan

HealthSavings+

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: **Blue Shield PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Blue Shield PPO Providers. You pay less for Covered Services when you use a Blue Shield PPO Provider than when you use an Out-of-Network Provider. You can find Blue Shield PPO Providers in this network by signing into your Transcarent app or by visiting Blue Shield's Find a Doctor website at HealthSavings+ for a list of your Plan's In-Network Providers.

Calendar Year medical and pharmacy Deductibles (CYD)[2,9]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Blue Shield PPO Provider[3]	When using any combination of Blue Shield PPO Providers[3] and Out-of-Network Providers[4]
Calendar Year medical and pharmacy Deductible	*Individual coverage*	$2,500	$4,000
	Family coverage	$5,000	$8,000

Calendar Year medical and pharmacy Out-of-Pocket Maximum[5,9]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Blue Shield PPO Provider[3]	When using any combination of Blue Shield PPO Providers[3] and Out-of-Network Providers[4]
Individual coverage	$6,700	$8,000
Family coverage	$12,000: individual $13,400: Family	$16,000: individual $16,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		50%	✔
Physician services				
Primary care office visit	30%	✔	50%	✔
Specialist care office visit	30%	✔	50%	✔
Physician home visit	30%	✔	50%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners and physician assistants.*	30%	✔	50%	✔
Acupuncture services *Combined with chiropractic services, up to 24 visits per Member, per Calendar Year.*	30%	✔	30%	✔
Chiropractic services *Combined with acupuncture services, up to 24 visits per Member, per Calendar Year.*	30%	✔	50%	✔
Family planning				
• Counseling, consulting, and education	$0		50%	✔
• Injectable contraceptive	$0		50%	✔
• Diaphragm fitting	$0		50%	✔
• Intrauterine device (IUD)	$0		50%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		50%	✔
• Implantable contraceptive	$0		50%	✔
• Tubal ligation	$0		50%	✔
• Vasectomy	$0	✔	50%	✔
Diagnosis and Treatment of the Cause of Infertility	30%	✔	50%	✔
Infertility Services[8] Prior Authorization is required through WINFertility. Please contact WINFertility at 1-877-451-3077. Members will have lifetime maximum benefit coverage for two (2) egg retrieval cycles. Infertility Services do not accrue to your Calendar Year Out-of-Pocket Maximum. Please see the full definition of a cycle on page 108 of the WINFertility section of this document. Infertility Services				

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
• Natural artificial inseminations Without ovum [oocyte or ovarian tissue (egg)] stimulation.	50%	✔	50%	✔
• Stimulated artificial inseminations With ovum [oocyte or ovarian tissue (egg)] stimulation.	50%	✔	50%	✔
• Gamete intrafallopian transfer (GIFT)	50%	✔	50%	✔
• Zygote intrafallopian transfer (ZIFT)	50%	✔	50%	✔
• In-vitro fertilization (IVF)	50%	✔	50%	✔
• Intracytoplasmic sperm injection (ICSI)	50%	✔	50%	✔
• Cryopreservation of sperm, oocytes, embryos limited to one retrieval and one year of storage per lifetime.	50%	✔	50%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	30%	✔	50%	✔
Physician services for pregnancy termination	$0	✔	$0	✔
Emergency Services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Blue Shield PPO Provider payment under Inpatient facility services/ Hospital services and stay.*	30%	✔	30%	✔
Emergency room Physician services	30%	✔	30%	✔
Urgent care center services	30%	✔	50%	✔
Ambulance services *This payment is for emergency or authorized transport. Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another is available.*	30%	✔	30%	✔
Outpatient Facility services				
Ambulatory Surgery Center	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Outpatient Department of a Hospital: surgery	30%	✔	50% Subject to a Benefit maximum of $210/day	✔

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Inpatient facility services				
Hospital services and stay	30%	✔	50% Subject to a Benefit maximum of $360/day	✔
Transplant services				
This payment is for all covered transplants except tissue and kidney and must be prior authorized and provided by a UC facility provider or approved BCBS COE. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.				
• Special transplant facility inpatient services	30%	✔	Not covered	
• Physician inpatient services	30%	✔	Not covered	
Bariatric surgery services, designated California counties				
Bariatric services must be prior authorized and provided by a UC facility provider or BCBS COE.				
Inpatient facility services	30%	✔	Not covered	
Outpatient Facility services	30%	✔	Not covered	
Physician services	30%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	30%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	30%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	30%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	30%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	30%	✔	50%	✔
Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Speech Therapy services				
Office location	30%	✔	50%	✔

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Outpatient Department of a Hospital	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
Durable medical equipment (DME)				
DME	30%	✔	50%	✔
Breast pump	$0		Not covered	
Glucose monitor	30%	✔	50%	✔
Peak Flow Meter	30%	✔	50%	✔
Prosthetic equipment and devices	30%	✔	50%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	30%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	30%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	30%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	30%	✔	50%	✔
Hospital-based SNF	30%	✔	50% Subject to a Benefit maximum of $360/day	✔
Hospice program services				
Pre-Hospice consultation	30%	✔	Not covered	
Routine home care	30%	✔	Not covered	
24-hour continuous home care	30%	✔	Not covered	

Benefits[6]	Your payment			
	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Short-term inpatient care for pain and symptom management	30%	✔	Not covered	
Inpatient respite care	30%	✔	Not covered	
Other services and supplies				
Transcarent Care visits for preventive care[10]	$0 when using Transcarent Care providers		$0 when using Transcarent Care providers	
Transcarent Care visits for primary and urgent care[10]	$30 until the Deductible is met, then 30%, when using Transcarent Care providers	✔	$30 until the Deductible is met, then 30%, when using Transcarent Care providers	✔
Blue Cross Blue Shield Global® Core Program[11]	20% when accessing Covered Services though Blue Shield Global® Core	✔	Not covered	
Diabetes care services				
• Devices, equipment, and supplies	30%	✔	50%	✔
• Self-management training	30%	✔	50%	✔
• Medical nutrition therapy	30%	✔	50%	✔
Dialysis services	30%	✔	50% Subject to a Benefit maximum of $210/day	✔
PKU product formulas and special food products	30%	✔	30%	✔
Allergy serum billed separately from an office visit	30%	✔	50%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $2,000 combined maximum per Member, per 36-month period.*	50%	✔	50%	✔
Travel immunizations and vaccinations	30%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits

Your payment

	When using Blue Shield PPO Provider[3]	CYD[2] applies	When using an Out-of-Network Provider[4]	CYD[2] applies
Outpatient services				
Physician Services	30%	✔	50%	✔
Outpatient Facility Services	30%	✔	50%	✔
Inpatient services				
Physician inpatient services	30%	✔	50%	✔
Hospital services	30%	✔	50%	✔
Residential Care	30%	✔	50%	✔
Other services				
Transcarent Care telebehavioral health visits[10]	$30 until the Deductible is met, then 30%, when using Transcarent Care providers	✔	$30 until the Deductible is met, then 30%, when using Transcarent Care providers	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Outpatient mental health services, except office visits and office-based opioid treatment
- Alcohol and Substance Use services
- Sleep Studies
- Inpatient facility services
- Durable Medical Equipment
- Hospice program services
- Continuous Glucose Monitoring
- CAR-T services
- Orthopedic surgery (I.e. Shoulder, Spine, Knee)
- Hearing Aids

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical or pharmacy Deductible. Some Covered Services received from Blue Shield PPO Providers are paid by the Claims Administrator before you meet any Calendar Year medical or pharmacy Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

*This Plan has a Blue Shield PPO Provider Deductible as well as a combined PPO Provider and Out-of-Network Provider Deductible. T*his means that any amounts you pay towards your Blue Shield PPO Provider Calendar Year Deductible also count towards your combined Blue Shield PPO Provider and Out-of-Network Provider Calendar Year Deductible.

For Family Coverage. The Family Deductible must be met by you and your Family members collectively within a Calendar Year.

3 Using Blue Shield PPO Providers:

Blue Shield PPO Providers have a contract to provide health care services to Members. When you receive Covered Services from a Blue Shield PPO Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Out-of-Network Providers:

Out-of-Network Providers do not have a contract to provide health care services to Members. When you receive Covered Services from an Out-of-Network Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Deductible or Out-of-Pocket Maximum and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the Calendar Year medical and pharmacy Deductible also count towards the Calendar Year Out-of-Pocket Maximum. Infertility services do not accrue to your Calendar Year Out-of-Pocket Maximum.

This Plan has a Blue Shield PPO OOPM as well as a combined Blue Shield PPO Provider and Out-of-Network Provider OOPM. This means that any amounts you pay towards your Blue Shield PPO Provider OOPM also count towards your combined Blue Shield PPO Provider and Out-of-Network Provider OOPM.

Notes

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit by a Blue Shield PPO Provider. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit. You can learn more about Preventive Health Services at www.blueshieldca.com/content/dam/bsca/en/member/docs/Preventive-Health-Guidelines.pdf.

8 Infertility Services:

Members will have lifetime maximum benefit coverage for two (2) egg retrieval cycles. . Please see the full definition of a cycle on page 108 of the WINFertility section of this document. Infertility Services Infertility Services do not accrue to your Calendar Year Out-of-Pocket Maximum. Infertility Benefit, Network, Pharmacy, and Prior Authorization & Utilization Management Services are administered by WINFertility. For more information about Infertility coverage, please contact WINFertility at: 1-877-451-3077.

Note: Once a member has completed two (2) cycles of egg retrievals as defined in this Benefits Booklet, the lifetime benefit maximum has been achieved for all infertility services, including Intrauterine Insemination (IUI) services.

9 Outpatient Prescription Drug Coverage (Navitus):

Outpatient prescription drug coverage is administered by Navitus. For information on outpatient prescription drug coverage, contact Navitus custom service at 833-8374308.

10 Transcarent Care:

Telehealth visits for preventive care are available at no Cost Share. Telehealth visits for primary and urgent care and telebehavioral health visits are available at $30 per visit, before the Calendar Year Deductible is met. Once your Calendar Year Deductible is met, you will be responsible for paying 30% Coinsurance per visit until the Calendar Year Out-of-Pocket Maximum is reached. For more information, visit member.Transcarent.com or call Transcarent Customer Service at 1-866-406-1182.

11 Blue Cross Blue Shield Global Core® Program:

For more information, see the *Blue Cross Blue Shield Global Core® Program* section and the *Inter-Plan Programs* section.

Plans may be modified to ensure compliance with Federal requirements or at any time UC Office of the President may require a benefit change at the direction of Systemwide HR.

lg091426;pb102126;102326

Introduction

Welcome! We are happy to have you as a Member of the HealthSavings+ plan.

This health Plan will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and other Health Care Providers. The types of services that are covered, the providers you can see, and your share of cost when you receive care may vary depending on the terms of the Plan, as described in further detail in this Benefit Booklet.

About this Benefit Booklet

The Benefit Booklet describes the health care coverage that is provided under the Plan. The Benefit Booklet tells you:

- Your eligibility for coverage;
- When coverage begins and ends;
- How you can access care;
- Which services are covered under your Plan (Covered Services);
- Which services are not covered under your Plan;
- When and how you must get prior authorization for certain services; and
- Important financial concepts, such as Copayment, Coinsurance, Deductible, and Out-of-Pocket Maximum.

This Benefit Booklet includes a *Summary of Benefits* section that lists your Cost Share for Covered Services. Use this summary to figure out what your cost will be when you receive care.

Please read this Benefit Booklet carefully. Some topics in this document are complex. For additional explanation on these topics, you may be directed to a section at the back of the Benefit Booklet called *Other important information about your Plan*. Pay particular attention to sections that apply to any special health care needs you may have. Be sure to keep this Benefit Booklet in your files for future reference.

Tables and images

In this Benefit Booklet, you will see the following tables and images to highlight key information:

 This table provides easy access to information 
Phone numbers and addresses
Answers to commonly-asked questions
Examples to help you better understand important concepts



This box tells you where to find additional information about a specific topic.



This box alerts you to information that may require you to take action.

"You" means the Member

In this Benefit Booklet, "you" or "your" means any Member enrolled in the Plan, including the Participant and all Dependents. "Your Employer" means the Participant's Employer.

Capitalized words have a special meaning

Some words and phrases in this Benefit Booklet may be new to you. Key terms with a special meaning within this Benefit Booklet are capitalized and defined in the *Definitions* section.

About this Plan

This is a Preferred Provider Organization (PPO) plan. In a PPO plan, you have the flexibility to choose the providers you see. You can receive care from In-Network Providers or Out-of-Network Providers. See the *How to access care* section for information about In-Network and Out-of-Network Providers.

High deductible health plans

This Plan is intended to qualify as a high deductible health plan. It is designed to be compatible with a health savings account (HSA). An HSA is a tax-advantaged savings account you can use to pay for medical expenses, including Cost Shares. Contributions to your HSA are taken from your paycheck before taxes and can be used tax-free for medical expenses. You can also save them on a tax-deferred basis for the future. Your HSA funds will roll over from year to year.

Please note that the Claims Administrator does not offer HSAs and you cannot sign up for an HSA directly through the Claims Administrator. If you are interested in learning more about HSAs, ask your Employer or consult with a financial advisor. You can also read more about HSAs in the *Notices about your Plan* section.

How to contact Customer Service

If you have questions at any time, we're here to help. The Claims Administrator's website and app are useful resources. Visit blueshieldca.com or use the Claims Administrator's mobile app to:

- Download forms;
- View or print a temporary ID card;

- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.

The Claims Administrator's contact information appears at the bottom of every page.

Contacting Customer Service

If you need information about	*You should contact*
Medical Benefits, including prior authorization and claims submission	Customer Service: 1-866-406-1182 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Prior authorization of oncology services	Evolent: (888) 999-7713

If you are hearing impaired, you may contact Customer Service through the Claims Administrator's toll-free TTY number: 711 at member.transcarent.com.

How to access care

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Health care professionals and facilities

This Plan covers care from Blue Shield PPO Providers and Out-of-Network Providers. You do not need a referral. However, some services do require prior authorization. See the *Utilization Management Program* section for information about prior authorization.

In-Network Providers (Blue Shield PPO Providers)

In-Network Providers have a contract with the Claims Administrator and agree to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services. As a result, when you receive Covered Services from an In-Network Provider, you will not be responsible for any costs in excess of the applicable Cost Share. When you receive Covered Services from an Out-of-Network Provider, you will be responsible for the applicable Cost Share and may also be responsible for additional costs, such as charges from the Out-of-Network Provider that are over the Allowable Amount and charges for services above any maximum Benefit allowance.

Some services will not be covered unless you receive them from an In-Network Provider. See the *Summary of Benefits* section to find out which Covered Services must be received from an In-Network Provider.

If a provider leaves this Plan's network, the status of the provider will change from In-Network to Out-of-Network. See the *Continuity of Care* section for more information on how to continue treatment with a former In-Network Provider.

Call Transcarent Customer Service, visit ***member.transcarent.com*** or ***blueshieldca.com*** and click on ***Find a Doctor***, *or visit* ***HealthSavings+*** for a list of your Plan's ***In-Network Providers***.

Out-of-Network Providers

Out-of-Network Providers do not have a contract with the Claims Administrator to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services.

Except for Emergency Services and services received at an In-Network Provider facility (Hospital, Ambulatory Surgical Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, you will pay more for Covered Services from an Out-of-Network Provider.

Out-of-Network Providers at an In-Network Provider Hospital or Ambulatory Surgical Center

When you receive care at one of these types of In-Network Provider facilities, some Covered Services may be provided by an Out-of-Network Provider. Your Cost Share will be the same as the amount due to an In-Network Provider under similar circumstances, and you will not be responsible for additional charges above the Allowable Amount, unless the Out-of-Network Provider provides you written notice of what they may charge and you consent to those terms.

Common types of providers
Primary Care Physicians (PCPs)
Other primary care providers, such as nurse practitioners and physician assistants
Physician Specialists, such as dermatologists and cardiologists
Physical, occupational, and speech therapists
Mental health providers, such as psychiatrists, psychologists, and licensed clinical social workers
Hospitals
Freestanding labs and radiology centers
Ambulatory Surgery Centers

Your Primary Care Physician

Primary Care Physicians (PCPs) provide primary care and help direct you to specialized care. We suggest your PCP be your first point of contact when you need Covered Services. However, you do not need to visit your PCP or get a referral from your PCP before you receive care.

PCPs may be:

General practitioners;
Family practitioners;
Internists;
Obstetrician/gynecologists; or
Pediatricians.

Transcarent Care

The Plan Administrator has contracted with Transcarent to provide telehealth and telebehavioral health (virtual) services. Virtual services through this program offer you an alternative to in-person office visits at no Cost Share for telehealth visits for preventive care. Telehealth visits for primary and urgent care and telebehavioral health

visits are available at $30 per visit, before the Calendar Year Deductible is met. Once your Calendar Year Deductible is met, you will be responsible for paying 30% Coinsurance per visit until the Calendar Year Out-of-Pocket Maximum is reached.

Benefits are available for ongoing primary care and mental health care visits by secure online video. Some age restrictions apply.

For more information, visit member.transcarent.com or call Transcarent Customer Service at 1-866-406-1182.

ID cards

The Claims Administrator will provide the Participant and any enrolled Dependents with identification cards (ID cards). Only you can use your ID card to receive Benefits. Your ID card is important for accessing health care, so please keep it with you at all times. Temporary ID cards are available at member.transcarent.com or on the Claims Administrator's mobile app.

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice.

Continuity of Care

Continuity of care with a Former In-Network Provider may be available if your provider leaves the Claims Administrator network or the Claims Administrator no longer contracts with your In-Network Provider for the services you are receiving.

Continuity of care may also be available to you when your Employer terminates its contract with the Claims Administrator and contracts with a new third-party administrator (TPA) that does not include the Claims Administrator's In-Network Provider in its network.

If your former In-Network Provider is no longer available to you for one of the reasons noted above, the Claims Administrator will notify you of the option to continue treatment with your Former In-Network Provider.

You can request to continue treatment with your Former In-Network Provider in the situations described above if you are currently receiving the following care:

Continuity of care with a Former In-Network Provider	
Qualifying conditions	***Timeframe***
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former In-Network Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner
Acute conditions	As long as the condition lasts
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	Within 180 days
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

If a condition falls within a qualifying condition under federal and state law, the more generous time frames would be followed.

To request continuity of care, please call Transcarent Customer Service. The Claims Administrator will confirm your eligibility and may review your request for Medical Necessity.

Under Federal law, the former In-Network Provider must accept the Claims Administrator's Allowable Amount as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the former In-Network Provider at the In-Network Provider Cost Share.

See the *Your payment information* section for more information about the Allowable Amount.

Second medical opinion

You can consult an In-Network or Out-of-Network Provider for a second medical opinion in situations including but not limited to:

- You have questions about the reasonableness or necessity of the treatment plan;
- There are different treatment options for your medical condition;
- Your diagnosis is unclear;
- Your condition has not improved after completing the prescribed course of treatment;
- You need additional information before deciding on a treatment plan; or
- You have questions about your diagnosis or treatment plan.

You do not need prior authorization from the Claims Administrator or your Physician for a second medical opinion.

Care outside of California

If you need medical care while traveling outside of California, you're covered. The Claims Administrator has relationships with health plans in other states, Puerto Rico, and the U.S. Virgin Islands through the BlueCard® Program. The Blue Cross Blue Shield Association can help you access care from participating and non-participating providers in those geographic areas.



See the ***Out-of-area services*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Emergency Services



If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

The Benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. Emergency Services are covered at the In-Network Provider Cost Share, even if you receive treatment from an Out-of-Network Provider.

If you cannot find an In-Network Provider – Gap Exception Process

Call Transcarent Customer Service if you need help finding an In-Network Provider who can provide the care you need close to home. If an In-Network Provider is not available, you can ask to see an Out-of-Network Provider at the In-Network Provider Cost Share. If the services cannot reasonably be obtained from an In-Network Provider, Transcarent will review your request and you will only be responsible for the In-Network Provider Cost Share. This is called an approved "Gap Exception".

Other ways to access care

For non-emergencies, it may be faster and easier to access care in one of the following ways. For more information, please call Transcarent Customer Service or visit member.transcarent.com.

Retail-based health clinics

Retail-based health clinics are conveniently located within stores and pharmacies. They are staffed with nurse practitioners who can provide basic medical care on a walk-in basis.

The Cost Share for Covered Services at an In-Network retail-based health clinic is described in the same Summary of Benefits.

Telebehavioral health services

Online telebehavioral health services for Mental Health and Substance Use Disorder Conditions are available through Transcarent. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider.

Urgent care centers

Urgent care centers are free-standing facilities that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

Ambulatory Surgery Centers

Many of the more common, uncomplicated, outpatient surgical procedures can be performed at an Ambulatory Surgery Center. Your cost at an Ambulatory Surgery Center may be less than it would be for the same outpatient surgery performed at a Hospital.

Health advice and education

Your Plan provides several ways for you to get health advice and access to health education and wellness services. These resources are available to you at no extra cost.

Health and wellness resources

Your Plan gives you access to a variety of health education and wellness services, such as:

- Prenatal and other health education programs;
- Healthy lifestyle programs to help you get more active, quit smoking, lower stress, and much more; and
- A health update newsletter.

Call Customer Service or visit member.transcarent.com to explore these resources.

Utilization Management Program

The Utilization Management Program is a service that reviews your treatment for clinical appropriateness. The Claims Administrator uses utilization management to help you and your providers identify the most appropriate and high-value way to use the Benefits of this Plan. Care management and palliative care can help you access the care you need to manage serious health conditions and complex treatment plans.

For written information about the Claims Administrator's ***Utilization Management Program***, call Customer Service or visit member.transcarent.com or blueshieldca.com.

Prior authorization

Coverage for some Benefits requires pre-approval from the Claims Administrator. This process is called prior authorization. Prior authorization requests are reviewed for Medical Necessity, available Plan Benefits, and clinically appropriate setting. The prior authorization process also identifies Benefits that are only covered from In-Network Providers or in a specific clinical setting.

All providers must obtain prior authorization when required. When prior authorization is required for an In-Network Provider but not obtained, the Claims Administrator will deny payment to your provider. You are not responsible for the Claims Administrator's portion of the Allowable Amount.

When prior authorization is required but not obtained by an Out-of-Network Provider, the responsibility is placed on **you, the member.** When the prior authorization was not obtained, or denied by the Claims Administrator, the services provided are **determined not to be a Benefit of the Plan or Medically Necessary**. The Claims Administrator may deny payment and **you will be responsible for all billed charges**. This includes international Hospital admissions.

You do not need prior authorization for Emergency Services or emergency Hospital admissions at In-Network or Out-of-Network facilities. For non-emergency inpatient services, your provider should request prior authorization at least five business days before admission.

Call Customer Service or visit member.transcarent.com or blueshieldca.com and click on Prior Authorization List for more details about medical and surgical services and select medically-administered prescription Drugs that require prior authorization.

Prescription Drugs administered by a Health Care Provider

Drugs administered by a Health Care Provider in a Physician's office, an infusion center, the Outpatient Department of a Hospital, or provided at home through a home infusion agency, are covered under the medical benefit and require prior authorization.

Frequently-utilized services that require prior authorization

Benefit	*Services that require prior authorization*
Medical	• Surgery • Prescription Drugs administered by a Health Care Provider • Non-emergency inpatient facility services, such as Hospitals and Skilled Nursing Facilities • Non-emergency ambulance services • Routine patient care received while enrolled in a clinical trial • Hospice program enrollment
Mental health and substance use disorder	• Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Behavioral Health Treatment • Electroconvulsive therapy • Neuropsychological and Psychological testing • Partial Hospitalization Program • Intensive Outpatient Program • Transcranial magnetic stimulation

When a decision will be made about your prior authorization request

Prior authorization or exception request	*Time for decision*
Routine medical and mental health and substance use disorder requests	Within five business days, but not to exceed seven calendar days
Expedited medical and mental health and substance use disorder requests	Within 72 hours

Expedited requests include urgent medical requests. Once the decision is made, your provider will be notified within 24 hours. Written notice will be sent to you and your provider within two business days.

While you are in the Hospital (inpatient utilization review)

When you are admitted to the Hospital, your stay will be monitored for continued Medical Necessity. If it is no longer Medically Necessary for you to receive an inpatient level of care, the Claims Administrator will send a written notice to you, your provider, and the Hospital. If you choose to stay in the Hospital past the date indicated in this notice, you may be held financially responsible for inpatient charges after that date. For an In-Network Hospital to hold you financially responsible, the In-Network Hospital must obtain from you in writing an acknowledgment of financial liability prior to rendering the services. Exceptions to inpatient utilization review include maternity and mastectomy care.

For maternity, the minimum length of an inpatient stay is 48 hours for a normal, vaginal delivery and 96 hours for a C-section. The provider and mother together may decide that a shorter length of stay is adequate.

For mastectomy, you and your provider determine the Medically Necessary length of stay after the surgery.

After you leave the Hospital (discharge planning)

You may still need care at home or in another facility after you are discharged from the Hospital. The Claims Administrator will work with you, Transcarent, your provider, and the Hospital's discharge planners to determine the most appropriate way to provide this care.

Using your Benefits effectively

Care management helps you coordinate your health care services and make the most efficient use of your Plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and repeated hospitalizations, and to help you with the transition from Hospital to home. A Transcarent care management nurse may contact you to see how we might help you manage your health condition. You may also request care management support by calling Transcarent Customer Service. A case manager can:

- Help you identify and access appropriate services;
- Instruct you about self-management of your health care conditions; and
- Identify community resources to lend support as you learn to manage a chronic health condition.

Alternative services may be offered when they are medically appropriate and only utilized when you, your provider, and the Claims Administrator mutually agree. The availability of these services is specific to you for a set period of time based on your health condition. The Claims Administrator does not give up the right to administer your Benefits according to the terms of this Benefit Booklet or to discontinue any alternative services when they are no longer medically appropriate. The Plan is not obligated to

cover the same or similar alternative services for any other Member in any other instance.

Managing a serious illness (palliative care services)

The Claims Administrator covers palliative care services if you have a serious illness. Palliative care provides relief from the symptoms, pain, and stress of a serious illness to help improve the quality of life for you and your family.

Palliative care services include access to Physicians and case managers who are specially trained to help you:

- Manage your pain and other symptoms;
- Maximize your comfort, safety, autonomy, and well-being;
- Navigate a course of care;
- Make informed decisions about therapy;
- Develop a survivorship plan; and
- Document your quality-of-life choices.

Your payment information

Paying for coverage

The Employer is responsible for funding the payment of claims for Benefits under this Plan.

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Claims Administrator's Allowable Amount.

Your Cost Share includes any:

- Deductible;
- Copayment amount; and
- Coinsurance amount.

When you see an Out-of-Network Provider, you are responsible for your Cost Share and all charges over the Allowable Amount.



See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Allowable Amount

The Allowable Amount is the maximum amount the Claims Administrator will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. The Claims Administrator's payment to the provider is the difference between the Allowable Amount and your Cost Share.

In-Network Providers agree to accept the Allowable Amount as payment in full for Covered Services, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections. When you see an In-Network Provider, you are responsible for your Cost Share.

Generally, the Claims Administrator will pay its portion of the Allowable Amount and you will pay your Cost Share. If there is a payment dispute between the Claims Administrator and an In-Network Provider over Covered Services you receive, the In-Network Provider must resolve that dispute with the Claims Administrator. You are not required to pay for the Claims Administrator's portion of the Allowable Amount. You are only required to pay your Cost Share for those services.

Out-of-Network Providers do not agree to accept the Allowable Amount as payment in full for Covered Services. When you see an Out-of-Network Provider, you are responsible for:

- Your Cost Share; and
- All charges over the Allowable Amount.

Calendar Year Deductible

The Deductible is the amount you pay each Calendar Year for Covered Services before the Claims Administrator begins payment. The Claims Administrator will pay for some Covered Services before you meet your Deductible. Typically, these are the ACA-mandated "Preventive Health Services" as described above in the Summary of Benefits.

Amounts you pay toward your Deductible count toward your Out-of-Pocket Maximum.

Amounts you pay over the Allowable Amount do not count toward your Deductible.

Some plans do not have a Deductible. For plans that do, there may be separate Deductibles for:

- An individual Member and an entire Family; and
- In-Network Providers and Out-of-Network Providers.

The Calendar Year per Family Deductible amount is shown in the *Summary of Benefits*. This Deductible must be made up of charges covered by the Plan, and must be satisfied once during each Calendar Year. Charges incurred by one or all of the Family members in combination will be used to calculate the Calendar Year Family Deductible. After the Calendar Year Deductible is satisfied for those Covered Services to which it applies, Benefits will be provided for Covered Services to any and all Family members.

If your Plan has individual coverage and you enroll a Dependent, your Plan will have Family coverage. Any amount you have paid toward the Deductible for your Plan with individual coverage will be applied to both the individual Deductible and the Family Deductible for your new Plan.

See the *Summary of Benefits* section for details on which Covered Services are subject to the Deductible and how the Deductible works for your Plan.

Copayment and Coinsurance

A Covered Service may have a Copayment or a Coinsurance. A Copayment is a specific dollar amount you pay for a Covered Service. A Coinsurance is a percentage of the Allowable Amount you pay for a Covered Service.

Your provider may ask you to pay your Copayment or Coinsurance at the time of service. For Covered Services that are subject to your Plan's Deductible, you are also responsible for all costs up to the Allowable Amount until you reach your Deductible.

You will continue to pay the Copayment or Coinsurance for each Covered Service you receive until you reach your Out-of-Pocket Maximum.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Services in a Calendar Year. Your Cost Share includes any applicable Deductible, Copayment, and Coinsurance and these amounts count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount

for Covered Services for the rest of the Calendar Year. If you want information about your Out-of-Pocket Maximum, you can call Transcarent Customer Service.

Some plans may have a separate Out-of-Pocket Maximum for:

- An individual Member and an entire Family;
- In-Network Providers and Out-of-Network Providers; and
- In-Network Providers and combined In-Network and Out-of-Network Providers.

If your Plan has Family coverage, there is an individual Out-of-Pocket Maximum within the Family Out-of-Pocket Maximum. This means an individual family member can meet the individual Out-of-Pocket Maximum before the entire Family meets the Family Out-of-Pocket Maximum.

If your Plan has individual coverage and you enroll a Dependent, your Plan will have Family coverage. Any amount you have paid toward the Out-of-Pocket Maximum for your Plan with individual coverage will be applied to both the individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum for your new Plan.

The following do not count toward your Out-of-Pocket Maximum:

- Charges for services that are not covered; and
- Charges over the Allowable Amount.

You will continue to be responsible for these costs even after you reach your Out-of-Pocket Maximum.

See the *Summary of Benefits* section for details on how the Out-of-Pocket Maximum works for your Plan.

Cost Share concepts in action

To recap, you are responsible for all costs for Covered Services until you reach any applicable Deductible. Once you reach any applicable Deductible, the Claims Administrator will pay the Allowable Amount for Covered Services, minus your Copayment or Coinsurance amounts, until you reach your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services. Exceptions are described above.

EXAMPLE
Cost to visit the doctor

Now that you know the basics, here is an example of how your Cost Share works. Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

Example: You visit the doctor for a sore throat. You have received Covered Services throughout the year and have already met your $500 Deductible. However, you have not yet met your $1,000 Out-of-Pocket Maximum.

Deductible: **$500**

Amount paid to date toward Deductible: **$500**

Out-of-Pocket Maximum: **$1,000**

Amount paid to date toward Out-of-Pocket Maximum: **$500**

In-Network Provider Copayment: **$30**

Out-of-Network Provider Copayment: **$40**

The Claims Administrator's Allowable Amount for the doctor's visit: **$100**

Out-of-Network Provider billed charge for the doctor's visit: **$140**

	In-Network Provider	***Out-of-Network Provider***
You pay	**$30** ($30 Copayment)	**$80** ($40 Copayment plus $40 for charges over Allowable Amount)
The Claims Administrator pays	$70 (Allowable Amount minus your Cost Share)	$60 (Allowable Amount minus your Cost Share)
Total payment to the doctor	$100 (Allowable Amount)	$140 (Billed charge)

In this example, because you have already met your Deductible, you are responsible for:

- In-Network Provider: the Copayment; or
- Out-of-Network Provider: the Copayment plus all charges over the Allowable Amount.

Claims

When you receive health care services, a claim must be submitted to request payment for Covered Services. A claim must be submitted even if you have not yet met your Deductible. The Claims Administrator uses claims information to track dollar amounts that count toward your Deductible and Out-of-Pocket Maximum.

When you see an In-Network Provider, your provider submits the claim to the Claims Administrator. When you see an Out-of-Network Provider, you must submit the claim to the Claims Administrator.

For claim forms, please call Transcarent Customer Service or visit member.transcarent.com or blueshieldca.com. You are required to submit your claim form and medical records within one year of the service date, or the claim will not be allowed.

See the *Out-of-Area services* section in the *Other important information about your plan* section for more information on claims outside of California.

How to submit a claim

Type of claim	*What to submit*	*Where to submit it*	*Due date*
Medical services	• The Claims Administrator claim form; and • The itemized bill from your provider	Blue Shield of California P.O. Box 272540 Chico, CA 95927	Within one year of the service date

Claim processing and payments

The Claims Administrator will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. The Claims Administrator cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by the Claims Administrator to the provider.

When you receive Covered Services from an Out-of-Network Provider, the Claims Administrator will send the payment to the Participant in most cases. However, the Claims Administrator may send the payment directly to the Out-of-Network Provider in certain circumstances, such as for Emergency Services, or when otherwise required by applicable state or federal law.



The Participant must make sure ***the Out-of-Network Provider*** receives the ***full billed amount***, whether or not the Claims Administrator makes payment to the Out-of-Network Provider.

Your coverage

This section explains eligibility and enrollment for this Plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this Plan

University of California Eligibility, Enrollment, Termination and Plan Administration Provisions

The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Complete Guide to Your UC Health Benefits". A copy of this booklet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members". A copy of this fact sheet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Plan changes

The Plan Sponsor has the right to change the Benefits and terms of this Plan as the law permits. This includes, but is not limited to, changes to:

- Terms and conditions;
- Benefits;
- Cost Shares;
- Premium Contributions; and
- Limitations and exclusions.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

Coordination of benefits

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits determines which plan will pay first when both plans have responsibility for paying the

medical claim. For more information, see the *Coordination of benefits, continued* section.

When coverage ends

Your coverage will end if:

- You are no longer eligible for coverage in this Plan;
- Your Employer terminates or discontinues the Plan;
- The Participant cancels coverage; or
- The Claims Administrator cancels or rescinds coverage.

There is no right to receive the Benefits of this Plan after coverage ends, except as described in the *Continuity of Care* and *Continuation of group coverage* sections.

If your Employer terminates or discontinues the Plan

Your Employer may terminate or discontinue your enrollment and/or your participation in the Plan at any time. Please see the *Notice about your UC Plan* section on page 100 for more information. This may occur if a Member or Dependent enrolled on the Plan is abusive or threatening to a representative of Transcarent, Blue Shield, or any vendor of UC while engaging in the activities of their health plan. UC staff will also file harassment and other complaints directly with UCOP officials if these are reported to UC. Please see UC GIRS (pg. 37, section "O") for more information at: https://ucnet.universityofcalifornia.edu/wp-content/uploads/tools-and-services/administrators/docs/gir-part-3.pdf. Also please see UC Systemwide policies on harassment at: https://policy.ucop.edu/doc/4000701/AbusiveConduct.

If the Participant cancels coverage

If the Participant decides to cancel coverage, coverage will end at 11:59 p.m. Pacific Time on a date determined by your Employer.

Reinstatement

If the Participant voluntarily cancels coverage, the Participant can contact the Employer for reinstatement options.

If the Claims Administrator cancels coverage

The Claims Administrator can cancel your coverage if you or your Dependent commit fraud or intentional misrepresentation of material fact.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

The Claims Administrator may cancel or rescind your coverage if you or your Dependent commit fraud or intentional misrepresentation of material fact. The Claims Administrator will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. Your Employer must provide you with a copy of the Notice of Cancellation, Rescission or Nonrenewal. Rescission voids the coverage as if it never existed. Cancellation or rescission is effective on the date specified in the Notice of Cancellation, Rescission or Nonrenewal and the Notice of

End of Coverage. UC Staff will also report you and your dependents involved directly to UCOP Systemwide Ethics & Compliance office.

Your Benefits

This section describes the Benefits your Plan covers. They are listed in alphabetical order so they are easy to find.

The Claims Administrator provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the Utilization Management Program; and
- The terms, conditions, limitations, and exclusions of this Plan.

You can receive many outpatient Benefits in a variety of settings, including your home, a Physician's office, an urgent care center, an Ambulatory Surgery Center, or a Hospital. The Claims Administrator's Utilization Management Program work with your provider to ensure that your care is provided safely and effectively in a setting that is appropriate to your needs. Your Cost Share for outpatient Benefits may vary depending on where you receive them.

See the *Exclusions and limitations* section for more information about Benefit exclusions and limitations.



See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Acupuncture services

Benefits are available for acupuncture evaluation and treatment. Acupuncture services must be provided by a Physician, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.

Contact Transcarent with questions about acupuncture services or acupuncture Benefits.

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests;
- Preparation and provision of allergy serum; and
- Allergy serum injections.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services

Benefits are available for ambulance services provided by a licensed ambulance or psychiatric transport van.

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and
- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

Air ambulance services are covered at the In-Network Provider Cost Share, even if you receive services from an Out-of-Network Provider.

Bariatric surgery Benefits

Benefits are available for bariatric surgery services. These Benefits include facility and Physician services for the surgical treatment of morbid obesity. Services must be prior authorized and provided by a UC facility provider or approved BCBS center of excellence.

Blue Cross Blue Shield Global® Core Program

Benefits will also be provided for Emergency and non-Emergency Covered Services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you live or plan to travel outside the United States, call the Member Services number on the back of the Identification card to find out your Blue Cross Blue Shield Global® Core Benefits. Benefits for services received outside of the United States may be different from services received in the United States. Once your Calendar Year Deductible is met, you will be responsible for paying 20% Coinsurance until the Calendar Year Out-of-Pocket Maximum is reached. 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 Blue Cross Blue Shield Global® Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is **(800) 810-BLUE (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 Blue Shield for prior authorization. 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 Utilization Management Program section in this booklet for further information. You can learn how to get prior authorization when you need to be admitted to the Hospital for emergency or non-emergency care.

For more information, see the *Inter-Plan Programs* section.

How Claims are Paid with Blue Cross Blue Shield Global® Core

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

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

- Physician services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global® Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front. Please also refer to the *Claims* section within this booklet for additional details.

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

- Call the Blue Cross Blue Shield Global® Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com. You will find the address for mailing the claim on the form.

Breast Health Screening services (Athena)

Members who receive mammography screening through a UC medical center are eligible to complete a breast health screening tool which provides additional information on the risk of developing breast cancer. High-risk individuals may receive telephonic or in-person counseling from an Athena breast health specialist. For further information on the Athena program, please go to the following site: http://athenacarenetwork.org.

Chiropractic services

Benefits are provided for chiropractic services performed by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination, subsequent office visits, adjustments, and plain film X-ray services in a chiropractor's office.

Benefits are limited to a per Member per Calendar Year visit maximum as shown on the *Summary of Benefits*.

Clinical trials for treatment of cancer or life-threatening diseases or conditions Benefits

Benefits are available for routine patient care when you have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition. A life-threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

The clinical trial must have therapeutic intent and the treatment must meet one of the following requirements:

- Your In-Network Provider determines that your participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by you; or
- You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate.

Coverage for routine patient care received while participating in a clinical trial requires prior authorization. Routine patient care is care that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial. The *Summary of Benefits* section lists your Cost Share for Covered Services. These Cost Share amounts are the same whether or not you participate in a clinical trial. Routine patient care does not include:

- The investigational item, device, or service itself;
- Drugs or devices not approved by the U.S. Food and Drug Administration (FDA);
- Travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
- Services normally provided by the research sponsor free for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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 other life-threatening diseases or conditions, and the study or investigation meets one of the following requirements:

- It is a drug trial conducted under an investigational new drug application reviewed by the FDA;
- It is a drug trial exempt under federal regulations from a new drug application; or
- It is federally funded or approved by one or more of the following:
    - One of 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; or
    - A designated Agency affiliate or research entity as described in the Affordable Care Act, including the Departments of Veterans Affairs, Defense, or Energy if the study has been reviewed and approved according to Health and Human Services guidelines.

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately-licensed Health Care Provider who is certified as a diabetes educator.

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

- Blood glucose monitors, including continuous blood glucose monitors and those designed to help the visually impaired, and all related necessary supplies;
- Insulin pens, syringes, pumps and all related necessary supplies;
- Disposable hypodermic needles and syringes needed for administration of insulin and glucagon;
- Blood and urine testing strips and tablets;
- Lancets and lancet puncture devices;
- Podiatric footwear and devices to prevent or treat diabetes-related complications;
- Medically Necessary foot care; and
- Visual aids, excluding eyewear and video-assisted devices, designed to help the visually impaired with proper dosing of insulin.

Your Plan also covers the replacement of a covered item after the expiration of its life expectancy.

Self-management training and medical nutrition therapy

Benefits are available for outpatient training, education, and medical nutrition therapy when directed or prescribed by your Physician. These services can help you manage your diabetes and properly use the devices, equipment, and supplies available to you. With self-management training, you can learn to monitor your condition and avoid frequent hospitalizations and complications.

Diagnostic X-ray, imaging, pathology, laboratory, and other testing services

Benefits are available for imaging, pathology, and laboratory services for preventive screening or to diagnose or treat illness or injury.

Benefits include:

- Basic diagnostic imaging services, such as plain film X-rays, ultrasounds, and mammography;
- Advanced diagnostic radiological and nuclear imaging, including CT, PET, MRI, and MRA scans;
- Clinical pathology services;
- Laboratory services;

- Other areas of non-invasive diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, cardiovascular and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Laboratory or imaging services performed as part of a preventive health screening are covered under the Preventive Health Services Benefit.

Dialysis Benefits

Benefits are available for dialysis services at a freestanding dialysis center, in the Outpatient Department of a Hospital, in a physician office setting, or in your home.

Benefits include:

- Renal dialysis;
- Hemodialysis;
- Peritoneal dialysis; and
- Self-management training for home dialysis.

Benefits do not include:

- Comfort, convenience, or luxury equipment; or
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Durable medical equipment

Benefits are available for durable medical equipment (DME) and supplies needed to operate the equipment. DME is intended for repeated use to treat an illness or injury, to improve the function of movable body parts, or to prevent further deterioration of your medical condition. Items such as orthotics and prosthetics are only covered when necessary for Activities of Daily Living.

Benefits include:

- Mobility devices, such as wheelchairs;
- Peak flow meter for the self-management of asthma;
- Glucose monitor, including continuous blood glucose monitors, and all related necessary supplies for the self-management of diabetes;
- Apnea monitors for the management of newborn apnea;
- Home prothrombin monitor for specific conditions;
- Oxygen and respiratory equipment;
- Disposable medical supplies used with DME and respiratory equipment;
- Required dialysis equipment and medical supplies;
- Medical supplies that support and maintain gastrointestinal, bladder, or bowel function, such as ostomy supplies;
- DME rental fees, up to the purchase price;
- Pasteurized donor human milk; and
- Breast pumps.

Benefits do not include:

- Environmental control and hygienic equipment, such as air conditioners, humidifiers, dehumidifiers, or air purifiers;
- Exercise equipment;
- Routine maintenance, repair, or replacement of DME due to loss or misuse, except when authorized;
- Self-help or educational devices;
- Speech or language assistance devices, except as specifically listed;
- Wigs;
- Adult eyewear;
- Video-assisted visual aids for diabetics;
- Generators;
- Any other equipment not primarily medical in nature; or
- Backup or alternate equipment.

See the *Diabetes care services* section for more information about devices, equipment, and supplies for the management and treatment of diabetes.

Orthotic equipment and devices

Benefits are available for orthotic equipment and devices you need to perform Activities of Daily Living and to treat foot complications due to diabetes. Orthotics are orthopedic devices used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for postoperative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts ordered by a Physician or podiatrist and used to treat mechanical problems of the foot, ankle, or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Orthotic devices intended to provide additional support for recreational or sports activities;
- Orthopedic shoes and other supportive devices for the feet, except as listed;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Prosthetic equipment and devices

Benefits are available for prosthetic appliances and devices used to replace a part of your body that is missing or does not function, and related supplies.

Benefits include:

- Tracheoesophageal voice prosthesis (e.g. Blom-Singer device) and artificial larynx for speech after a laryngectomy;
- Artificial limbs and eyes;
- Internally-implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if surgery to implant the device is covered;
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;
- Supplies necessary for the operation of prostheses, including orthotics;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Speech or language assistance devices, except as listed;
- Dental implants;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Emergency Benefits

Benefits are available for Emergency Services received in the emergency room of a Hospital or other emergency room licensed under state law. The Emergency Benefit also includes Hospital admission when inpatient treatment of your Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an Emergency Medical Condition at any Hospital, even if it is an Out-of-Network Hospital.



If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

Benefits include:

- Physician services;
- Emergency room facility services; and
- Inpatient Hospital services to stabilize your Emergency Medical Condition.

Emergency Services and follow-up health care treatment are provided without a Cost Share for Members treated following a rape or sexual assault for the first nine months after the Member begins treatment. Follow-up health care treatment includes medical

or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

The Cost Share waiver is applicable to follow-up health care treatment provided by an In-Network Provider, any provider of Emergency Services, or an Out-of-Network Provider when Blue Shield has approved your request to receive services from the Out-of-Network Provider at the In-Network Provider Cost Share. For more information, please see the If you cannot find an In-Network Provider section. The Cost Share waiver will only apply to services the treating provider has identified in their claim submission using accurate diagnosis codes specific to rape or sexual assault.

After your condition stabilizes

Once your Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

- Be released from the emergency room if you do not need further treatment;
- Receive additional inpatient treatment at the In-Network Hospital; or
- Transfer to an In-Network Hospital for additional inpatient treatment if you received treatment of your Emergency Medical Condition at an Out-of-Network Hospital.

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or unborn child, stabilize means delivery, including the placenta. Post-stabilization care is Medically Necessary treatment received after the treating Physician determines the Emergency Medical Condition is stabilized.

If you are admitted to the Hospital for Emergency Services, you should notify the Claims Administrator within 24 hours or as soon as possible after your condition has stabilized.

Family planning and Infertility Benefits

Family planning

Benefits are available for family planning services without illness or injury.

Benefits include:

- Counseling, consulting, and education;
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Tubal ligation; and
- Vasectomy.

Family planning services may also be covered under the Preventive Health Services Benefit.

Infertility Benefits

Prior authorization is required through WINFertility. Refer to Infertility Services Network section for benefit details. For eligibility and benefit inquiries, contact WINFertility at 877-451-3077, or visit managed.winfertility.com/universityofcalifornia.

Fertility preservation services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Services that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, Standard Fertility Preservation Services, including retrieval and cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos, are a Covered Service and do not fall under the scope of Infertility Benefits described in the *Family Planning and Infertility Benefits* section.

Blue Shield will provide written notice explaining the covered storage period within 30 business days after receipt of a claim for cryopreservation services.

Blue Shield will provide written notice 90 calendar days prior to the expiration of the storage periods.

Gender affirmation services

The Plan covers gender affirmation services for the treatment of gender dysphoria. Services and supplies are provided in connection with gender affirmation when the following criteria are met:

- A documented diagnosis of gender dysphoria including all of the following:
  - A strong desire to be treated as a gender other than that assigned; and
  - Disorder is not a symptom of another mental disorder (e.g., schizophrenia); and
  - Disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coverage includes Medically Necessary services when criteria are met such as:

- Feminizing mammoplasty;
- Male chest reconstruction;
- Mastectomy;
- Gender-confirming facial surgery;
- Hysterectomy;
- Oophorectomy;
- Penectomy;
- Orchiectomy;
- Feminizing genitoplasty;
- Metoidioplasty;
- Phalloplasty;
- Scrotoplasty;
- Voice masculinization or feminization;
- Hormone therapy related to gender dysphoria or intersex conditions;
- Gender-affirming gynecological care; and
- Voice therapy related to gender dysphoria or intersex conditions.

This coverage is provided according to the terms and conditions of this Plan, including Medical Necessity requirements and utilization management. Coverage for some Benefits requires prior authorization. See the *Utilization Management Program* section for more information about prior authorization, and the *Exclusions and limitations* section for more information about Benefit exclusions and limitations.

Prescription drug coverage for gender affirming care is administered by Navitus. For information or details on this coverage, contact Navitus customer service at 833-837-4308.

Hearing Aid Services

Your Plan provides coverage for hearing aid services, subject to the conditions and limitations listed below.

The hearing aid services Benefit provides a combined maximum allowance as shown on the *Summary of Benefits* towards covered hearing aids and services as specified below. You are not required to use an In-Network Provider to obtain these services as the Claims Administrator does not maintain a network of contracted providers for these services. You may obtain these services from any provider of your choosing and submit a claim to the Claims Administrator for reimbursement for Covered Services up to the combined maximum allowance. For information on submitting a claim, see the *Claims* section.

Hearing Aids and Ancillary Equipment

The Benefit allowance is provided for hearing aids and ancillary equipment up to the maximum per Member shown in the *Summary of Benefits*. You are responsible for the cost of any hearing aid services which are in excess of this Benefit allowance.

The hearing aid Benefit includes: a hearing aid instrument, monaural or binaural including ear mold(s), the initial battery, cords and other ancillary equipment. The Benefit also includes visits for fitting, counseling and adjustments.

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
- Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids above the maximum allowance shown in the *Summary of Benefits*;
- Surgically implanted hearing devices.

Hearing aids and ancillary equipment are not included in the calculation of the Calendar Year Out-of-Pocket Maximum amount.

Home health services

Benefits are available for home health services. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

Benefits are available from an In-Network home health care agency for diagnostic and treatment services received in your home under a written treatment plan approved by your Physician.

Benefits include:

- Intermittent home care for skilled services from:
  - Registered nurses;
  - Licensed vocational nurses;
  - Physical therapists;
  - Occupational therapists;
  - Speech and language pathologists;
  - Licensed clinical social workers; and
  - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

- Fewer than seven days per week; or
- Daily, for fewer than eight hours per day, up to 21 days.

Benefits are limited to a visit maximum as shown in the *Summary of Benefits* section for home health agency visits. For this Benefit, coverage includes:

- Up to four visits per day, two hours maximum per visit, with a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or licensed clinical social worker. A visit of two hours or less is considered one visit. Nursing visits cannot be combined to provide Continuous Nursing Services.
- Up to four hours maximum per visit with a Home Health Aide. A visit of four hours or less is considered one visit.

Benefits do not include:

- Continuous Nursing Services provided by a registered nurse or a licensed vocational nurse, on a one-to-one basis, in an inpatient or home setting. These services may also be described as "shift care" or "private-duty nursing."

Home infusion and injectable medication services

Benefits are available through an In-Network home infusion agency for home infusion, enteral, and injectable medication therapy.

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with an In-Network home infusion agency;
- Administration of parenteral nutrition formulations and solutions;
- Administration of enteral nutrition formulas and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

See the *PKU formulas and special food products* section for more information.

There is no Calendar Year visit maximum for home infusion agency services.

This Benefit does not include:

- Insulin;
- Insulin syringes; and

Services related to hemophilia, which are described below.

Hemophilia home infusion services

Benefits are available for hemophilia home infusion products and services for the treatment of hemophilia and other bleeding disorders. Benefits must be prior authorized and provided in the home or in an infusion suite managed by an In-Network Hemophilia Home Infusion Provider.

Benefits include:

- 24-hour service;
- Home delivery of hemophilia infusion products;
- Blood factor product;
- Supplies for the administration of blood factor product; and
- Nursing visits for training or administration of blood factor products.

There is no Calendar Year visit maximum for hemophilia home infusion agency services.

Benefits do not include:

- In-home services to treat complications of hemophilia replacement therapy; or
- Self-infusion training programs, other than nursing visits to assist in administration of the product.

Most In-Network home health care and home infusion agencies are not In-Network Hemophilia Home Infusion Providers. For a list of In-Network Hemophilia Home Infusion Providers, please call Transcarent Customer Service or visit member.transcarent.com or blueshieldca.com.

Hospice program services

Benefits are available through an In-Network Hospice Agency for specialized care if you have been diagnosed with a terminal illness with a life expectancy of one year or less. When you enroll in a Hospice program, you agree to receive all care for your terminal illness through the Hospice Agency. Hospice program enrollment is prior authorized for a specified period of care based on your Physician's certification of eligibility. The period of care begins the first day you receive Hospice services and ends when the specified timeframe is over or you choose to receive care for your terminal illness outside of the Hospice program.

The authorized period of care is for two 90-day periods followed by unlimited 60-day periods, depending on your diagnosis. Your Hospice care continues through to the next period of care when your Physician recertifies that you have a terminal illness. The Hospice Agency works with your Physician to ensure that your Hospice enrollment continues without interruption. You can change your In-Network Hospice Agency only once during each period of care.

A Hospice program provides interdisciplinary care designed to ease your physical, emotional, social, and spiritual discomfort during the last phases of life, and support your primary caregiver and your family. Hospice services are available 24 hours a day through the Hospice Agency.

While enrolled in a Hospice program, you may continue to receive Covered Services that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;
- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;
- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;
- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

- Services provided by an Out-of-Network Hospice Agency, except in certain circumstances where there are no In-Network Hospice Agencies in your area and services are prior authorized.

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
  - Semiprivate Hospital room, or private room if Medically Necessary;

    - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
    - General and specialized nursing care; and
    - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:
    - Operating, recovery, labor and delivery, and other specialized treatment rooms;
    - Anesthesia, oxygen, medicines, and IV solutions;
    - Clinical pathology, laboratory, radiology, and diagnostic services and supplies;
    - Dialysis services and supplies;
    - Blood and blood products;
    - Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
    - Radiation therapy, chemotherapy, and associated supplies;
    - Therapy services, including physical, occupational, respiratory, and speech therapy;
    - Acute detoxification;
    - Acute inpatient rehabilitative services; and
    - Emergency room services resulting in admission.

Medical treatment of the teeth, gums, jaw joints, and jaw bones

Benefits are available for outpatient, Hospital, and professional services provided for treatment of the jaw joints and jaw bones, including adjacent tissues.

Benefits include:

- Treatment of odontogenic and non-odontogenic oral tumors (benign or malignant);
- Stabilization of natural teeth after traumatic injury independent of disease, illness, or any other cause;
- Surgical treatment of temporomandibular joint syndrome (TMJ), such as intraoral removable prosthetic devices or appliances, encompassing fabrication, insertion, adjustment of such prosthetic device;
- Non-surgical treatment of TMJ;
- Orthognathic surgery to correct a skeletal deformity;
- Dental and orthodontic services directly related to cleft palate repair;
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers; and
- General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status when:
    - The Member is younger than seven years old; or
    - The Member is developmentally disabled; or
    - The Member's health is compromised and general anesthesia is Medically Necessary.

Benefits do not include:

- Diagnostic dental services such as oral examinations, oral pathology, oral medicine, X-rays, and models of the teeth, except when related to surgical and non-surgical treatment of TMJ;
- Preventive dental services such as cleanings, space maintainers, and habit control devices except as covered under the Preventive Health Services Benefit;
- Periodontal care such as hard and soft tissue biopsies and routine oral surgery including removal of teeth;
- Reconstructive or restorative dental services such as crowns, fillings, and root canals;
- Orthodontia for any reason other than cleft palate repair;
- Dental implants for any reason other than cleft palate repair;
- Any procedure to prepare the mouth for dentures or for the more comfortable use of dentures;
- Alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums, or periodontal structures, or to support natural or prosthetic teeth; or
- Fluoride treatments for any reason other than preparation of the oral cavity for radiation therapy or for Benefits covered under Preventive Health Services.

Mental Health and Substance Use Disorder Benefits

The Claims Administrator administers Mental Health Services and Substance Use Disorder Services for Members. See the *Out-of-area services* section for an explanation of how Benefits are administered for out-of-state services.

An In-Network Provider must get prior authorization from the Claims Administrator for all non-emergency Hospital admissions for Mental Health Services and Substance Use Disorder Services, and for certain outpatient Mental Health and Substance Use Disorder Services. See the *Utilization Management Program* section for more information about prior authorization.

Office visits

Benefits are available for professional services for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorder Conditions. You can receive these services at an office visit, including Physician office visit, or in an individual, Family, or group professional outpatient setting, or as a telebehavioral health service.

Benefits include therapy, counseling and medication management.

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorder Conditions. You can receive these other outpatient services in a facility, office, clinic, home, or other non-institutional setting.

Other Outpatient Mental Health and Substance Use Disorder Services include, but are not limited to:

- Behavioral Health Treatment – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, prescribed by a Physician or licensed psychologist and provided under a treatment plan to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism;
- Electroconvulsive therapy – the passing of a small electric current through the brain to induce an anesthesia-controlled seizure, used in the treatment of severe psychiatric conditions;
- Intensive Outpatient Program – outpatient care for Mental Health Conditions or Substance Use Disorder Conditions when your condition requires structure, monitoring, and medical/psychological intervention for nine to nineteen hours a week;
- Office-based opioid treatment – substance use disorder maintenance therapy, including methadone maintenance treatment;
- Partial Hospitalization Program – an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services that are at a minimum 20 hours per week;
- Neuropsychological and Psychological Testing – testing to diagnose a Mental Health Condition and/or to assess the health of certain brain functions; and
- Transcranial magnetic stimulation – a non-invasive method of delivering magnetic stimulation to the brain for the treatment of severe depression.

Benefits do not include treatment not supported by current generally accepted standards of Mental Health and Substance Use Disorder Care, including:

- Outdoor, youth or wilderness programs and accommodations;
- Equine assisted therapy;
- Treatment for the purpose of providing respite or day care;
- Educational services; or
- Any other treatment or other facilities that provide primarily a supportive environment and address long-term social needs.

In addition, Benefits do not include reimbursement of a parent, legal guardian, or conservator for participation in such treatment or programs.

Inpatient Services

Benefits are available for inpatient facility and professional services for the treatment of Mental Health Conditions and Substance Use Disorder Conditions in:

- A Hospital; or
- A free-standing residential treatment center that provides 24-hour care when you do not require acute inpatient care.

Medically Necessary inpatient substance use disorder withdrawal management (detoxification) is covered under the Hospital services Benefit.

Services in the following settings are not covered under this Plan:

- **Wilderness therapy programs**, outdoor behavioral or survival camps, outdoor adventure programs, or similar environments that combine therapy with outdoor or survival activities;
- **Alternative residential or behavioral programs** that are primarily educational, recreational, custodial, or that emphasize discipline, self-esteem, or life-skills training rather than clinical treatment;
- **Academic or boarding schools**, **therapeutic schools**, or **residential academies** that provide educational or life-skills instruction, even when they include a behavioral health or counseling component; and
- Any **educational or non-medical services** provided in conjunction with a behavioral, emotional, or substance-use program, camp, or residential facility.

These services are **excluded** even if recommended by a physician, mental health professional, or court order. Coverage is limited to facilities and programs that meet UC's medical necessity criteria and are **licensed and accredited** to provide **clinical mental health or substance use disorder treatment** in a **medical or residential treatment center** setting only.

Physician and other professional services

Benefits are available for services performed by a Physician, surgeon, or other Health Care Provider to diagnose or treat a medical condition.

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;
- Second medical opinions;
- Administration of injectable medications that must be administered by a Health Care Provider;
- Administration of radiopharmaceutical medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits; and
- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment.

See the *Mental Health and Substance Use Disorder Benefits* section for information on Mental Health and Substance Use Disorder office visits and Other Outpatient Mental Health and Substance Use Disorder services.

Medical nutrition therapy

Benefits are provided for office visits for medical nutrition therapy for treatment of eating disorders such as anorexia nervosa and bulimia nervosa only. Treatment must be prescribed by a Physician and provided by a Registered Dietitian Nutritionist or other appropriately-licensed or certified Health Care Provider. You can continue to

receive medical nutrition therapy as long as your treatment is Medically Necessary. The Claims Administrator may periodically review the provider's treatment plan and records for Medical Necessity. See the *Diabetes care services* section for information about medical nutrition therapy for diabetes.

PKU formulas and special food products

Benefits are available for formulas and special food products if you are diagnosed with phenylketonuria (PKU). The items must be part of a diet prescribed and managed by a Physician or appropriately-licensed Health Care Provider.

Benefits include:

- Enteral formulas;
- Parenteral nutrition formulations; and
- Special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods including shakes, snack bars, used by the general population;
- Additives such as thickeners, enzyme products, or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

Benefits are available for the diagnosis and treatment of conditions of the foot, ankle, and related structures. These services, including surgery, are generally provided by a licensed doctor of podiatric medicine.

Pregnancy and maternity care

Benefits are available for maternity care services.

Benefits include:

- Midwife and Doula care;
- Lactation consultation;
- Prenatal care;
- Postnatal care;
- Involuntary complications of pregnancy;
- Inpatient Hospital services including labor, delivery, and postpartum care;
- Elective newborn circumcision within 18 months of birth; and
- Abortion and abortion-related services, including pre-abortion and follow-up services.

See the *Diagnostic X-ray, imaging, pathology, and laboratory services* and *Preventive Health Services* sections for information about coverage of genetic testing and diagnostic procedures related to pregnancy and maternity care.

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section. The attending Physician, in consultation

with the mother, may determine that a shorter length of stay is adequate. If your Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Midwife and Doula Care

Your UC Plan covers Medically Necessary services provided by licensed midwives, certified nurse midwives and Doulas. A licensed midwife, certified nurse midwife or Doula must be a licensed Health Care Provider or sanctioned to operate under another Health Care Provider's license.

Your Plan does not allow any gap exceptions for a licensed midwife, certified nurse midwife or Doula to be considered an In-Network Provider if they do not participate in the Blue Shield PPO network, or if they are not sanctioned to operate under the license of a Health Care Provider who participates in the Blue Shield PPO network.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage. These services are covered as Preventive Health Services when billed with appropriate preventive coding. The Claims Administrator covers Preventive Health Services whether you receive them from an In-Network Provider or from an Out-of-Network Provider.

Benefits include:

- Evidence-based items, drugs, or services that had in effect on January 1, 2025 a rating of A or B in the recommendations of the United States Preventive Services Task Force (USPSTF), which the California Department of Public Health can modify or supplement. Examples of recommendations are:
    - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
    - Screening for HPV;
    - Screening for osteoporosis; and
    - Health education;
- Immunizations that had in effect on January 1, 2025 a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, as of January 1, 2025, which the California Department of Public Health can modify or supplement, as well as immunizations needed for the purpose of travel;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines, as periodically updated, supported by the Health Resources and Services Administration as of January 1, 2025, which the California Department of Public Health can

modify or supplement. This includes screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;
- California Prenatal Screening Program; and
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration as of January 1, 2025, which the California Department of Public Health can modify or supplement. See the *Family planning Benefits* section for more information.

If there is a new recommendation or guideline in any of the resources described above, the Claims Administrator will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the Plan Year that begins after that year.



Call Customer Service or visit member.transcarent.com or ***blueshieldca.com/preventive*** for more information about ***Preventive Health Services***.

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

- Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to:
  - Improve function; or
  - Create a normal appearance to the extent possible;
- Dental and orthodontic surgery services directly related to cleft palate repair; and
- Surgery and surgically-implanted prosthetic devices in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Benefits do not include:

- Cosmetic surgery, which is surgery that is performed to alter or reshape normal structures of the body to improve appearance;
- Reconstructive Surgery when there is a more appropriate procedure that will be approved; or
- Reconstructive Surgery to create a normal appearance when it offers only a minimal improvement in appearance.

In accordance with the WHCRA, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered for either breast to restore and achieve symmetry following a mastectomy, and for the treatment of the physical complications of a mastectomy, including lymphedemas. For coverage of prosthetic devices following a mastectomy, see the *Durable medical equipment* section. Medically Necessary services will be determined by your attending Physician in consultation with you.

Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons, except as required under the WHCRA.

Rehabilitative and habilitative services

Benefits are available for outpatient rehabilitative and habilitative services. Rehabilitative services help to restore the skills and functional ability you need to perform Activities of Daily Living when you are disabled by injury or illness. Habilitative services are therapies that help you learn, keep, or improve the skills or functioning you need for Activities of Daily Living.

These services include physical therapy, occupational therapy, and speech therapy. Treatment must be provided by an appropriately-licensed or certified Health Care Provider.

See the *Hospital services* section for information about inpatient rehabilitative Benefits.

See the *Home health services* and *Hospice program services* sections for information about coverage for rehabilitative and habilitative services provided in the home.

Physical therapy

Physical therapy uses physical agents and therapeutic treatment to develop, improve, and maintain your musculoskeletal, neuromuscular, and respiratory systems. Physical agents and therapeutic treatments include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage performed as a part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Provider.

Occupational therapy

Occupational therapy is treatment to develop, improve, and maintain the skills you need for Activities of Daily Living, such as dressing, eating, and drinking.

Speech therapy

Speech therapy is used to develop, improve, and maintain vocal or swallowing skills that have not developed according to established norms or have been impaired by a diagnosed illness or injury. Benefits are available for outpatient speech therapy for the treatment of:

- A communication impairment;
- A swallowing disorder;
- An expressive or receptive language disorder; and
- An abnormal delay in speech development.

Skilled Nursing Facility (SNF) services

Benefits are available for treatment in the Skilled Nursing unit of a Hospital or in a free-standing Skilled Nursing Facility (SNF) when you are receiving Skilled Nursing or rehabilitative services. This Benefit also includes care at the Subacute Care level.

Benefits must be prior authorized and are limited to a day maximum per benefit period, as shown in the *Summary of Benefits* section. A benefit period begins on the date you are admitted to the facility. A benefit period ends 60 days after you are discharged from the facility or you stop receiving Skilled Nursing services. A new benefit period can only begin after an existing benefit period ends.

Transplant services

Benefits are available for tissue and kidney transplants and special transplants. Services must be prior authorized and provided by a UC facility provider or approved BCBS center of excellence.

Tissue and kidney transplants

Benefits are available for facility and professional services provided in connection with human tissue and kidney transplants when you are the transplant recipient.

Benefits include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special transplants

Benefits are available for special transplants only if:

- The procedure is performed at a special transplant facility contracting with the Claims Administrator, or if you access this Benefit outside of California, the procedure is performed at a transplant facility designated by the Claims Administrator; and
- You are the recipient of the transplant.

Special transplants are:

- Human heart transplants;
- Human lung transplants;
- Human heart and lung transplants in combination;
- Human liver transplants;
- Human kidney and pancreas transplants in combination;
- Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
- Pediatric human small bowel transplants; and
- Pediatric and adult human small bowel and liver transplants in combination.

Donor services

Transplant Benefits include coverage for donation-related services for a living donor, including a potential donor, or a transplant organ bank. Donor services must be directly related to a covered transplant for a Member of this Plan.

Donor services include:

- Donor evaluation;
- Harvesting of the organ, tissue, or bone marrow; and
- Treatment of medical complications for 90 days after the evaluation or harvest procedure.

Travel expense reimbursement for bariatric, gender affirmation and transplant services

You may be eligible for reimbursement of your travel expenses for the following Covered Services: bariatric, gender affirmation and transplant services, including preoperative and postoperative visits, if you live:

- at least 50 miles away from the nearest UC facility or BCBS center of excellence Provider of eligible bariatric Covered Services;
- at least 75 miles away from the nearest provider of your choosing that will be providing you with gender affirmation Covered Services; or
- at least 75 miles away from the nearest UC facility or BCBS center of excellence Provider of eligible transplant Covered Services.

Travel must be within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands.

For travel expense reimbursement, you must submit receipts, claim forms, and any other documentation required by the Claims Administrator. You must also have a prior authorization approved for the eligible Covered Service for which you traveled on file with the Claims Administrator prior to reimbursement, if applicable.

The Claims Administrator's maximum travel expense reimbursement will not exceed the per Member, per category of Covered Service maximum as listed below:

Bariatric: $5,000 per Calendar Year
Gender affirmation: $10,000 per Calendar Year
Transplant: $10,000 per Calendar Year

Expenses must be reasonably necessary. Reimbursable expenses include, if appropriate:

- Transportation to and from the facility to receive eligible Covered Services;
- Hotel accommodations if one or more overnight stays are required to obtain eligible Covered Services. Limited $250 per night for covered Member and $250 per night for covered caregiver. Minor donor recipients are eligible to have 2 caregivers. Maximum of either $500 or $750 per

night. Only the room is covered. All other hotel expenses are excluded; and

- Meals. Maximum of $150 per day for covered Member and covered caregiver for food and meal delivery services. Expenses for tobacco, alcohol, drugs, phone, television, and recreation are excluded.

This travel expense reimbursement is subject to the Calendar Year Deductible. You must meet the Calendar Year Deductible before any travel expense reimbursement will apply. For travel reimbursement, you do not need to submit claim forms to the Claims Administrator until you have reached your Calendar Year Deductible.

Certain travel expense reimbursements may be tax reportable. When required, the Claims Administrator will issue a Form 1099-MISC to you, reporting travel expense reimbursements. The Claims Administrator does not provide tax advice. If you have tax questions about travel expense reimbursements, you should consult with your tax advisor.

Reimbursement is not available if the reimbursements themselves or the underlying services would be unlawful under applicable law.

Urgent care services

Benefits are available for urgent care services you receive at an urgent care center or during an after-hours office visit. You can access urgent care instead of going to the emergency room if you have a medical condition that is not life-threatening but prompt care is needed to prevent serious deterioration of your health.

See the *Out-of-area services* section for information on urgent care services outside California.

Exclusions and limitations

This section describes the general exclusions and limitations that apply to all your Plan Benefits.

	General exclusions and limitations
1	This Plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.
2	Routine physical examinations solely for licensure, employment, insurance, court order, parole, or probation. This exclusion does not apply to Medically Necessary services that are required by law to be covered under this Plan for Mental Health Services and Substance Use Disorder Services.
3	Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
4	Routine foot care items and services that are not Medically Necessary, including: • Callus treatment; • Corn paring or excision; • Toenail trimming; • Over-the-counter shoe inserts or arch supports; or • Any type of massage procedure on the foot. This exclusion does not apply to items or services provided through an In-Network Hospice Agency or covered under the diabetes care Benefit.
5	Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care. Custodial care is assistance with Activities of Daily Living furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board. Domiciliary care is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
6	Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through an In-Network Hospice Agency.
7	Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the *Home infusion and injectable medication services* and *PKU formulas and special food products* sections, or as

General exclusions and limitations	
	provided through an In-Network Hospice Agency. This exclusion does not apply to Medically Necessary services that are required by law to be covered under this Plan for Mental Health Services and Substance Use Disorder Services.
8	For any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition.
9	Orthoptics or vision training except when Medically Necessary, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the *Prosthetic equipment and devices* section. Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
10	Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the *Prosthetic equipment and devices* section.
11	Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections.
12	Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.
13	Treatment of sexual dysfunctions and sexual inadequacies. This exclusion does not apply to the treatment of organically-based conditions.
14	Home testing devices and monitoring equipment. This exclusion does not apply to items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.
15	Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.
16	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
17	Services provided by an individual or entity that:

General exclusions and limitations

	• Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services.
18	Select physical and occupational therapies, such as: • Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan; and • Vocational, educational, recreational, art, dance, music, or reading therapy. This exclusion does not apply to Medically Necessary services that the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.
19	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section, or to Medically Necessary services that are required by law to be covered under this Plan for Mental Health Services and Substance Use Disorder Services.
20	Services or Drugs that are Experimental or Investigational in nature.
21	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met.
22	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
23	Member convenience items or services, such as internet, phones, televisions, guest trays, personal hygiene items, and food delivery services.

	General exclusions and limitations
24	Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections.
25	Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if the Claims Administrator provides payment for such services, we will be entitled to establish a lien up to the amount paid by the Claims Administrator for the treatment of such injury or disease.
26	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
27	Hospital care programs or services provided in a home setting (Hospital-at-home programs).
28	Services that you are not legally obligated to pay, or for which you are not charged. This exclusion does not apply to Preventive Health Services.
29	Prescribed Drugs and medicines for outpatient care except as provided through an In-Network Hospice Agency when the Member is receiving Hospice Services and except as may be provided under the Home Infusion/Home Injectable Therapy Benefits in the Covered Services section.
30	Outpatient prescription Drugs.
31	Rehabilitative Services, except as specifically provided in the *Home health services*, *Hospice program services*, *Hospital services*, or *Rehabilitative and habilitative services* sections.
32	Mammographies, Papanicolaou tests or other FDA-approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, or annual health appraisal exams by Out-of-Network Providers.
33	Speech therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under the *Home health services*, *Hospice program services*, or *Rehabilitative and habilitative services* sections. This exclusion does not apply to services provided for the treatment of Mental Health or Substance Use Disorder Conditions.
34	Wilderness therapy or other forms of outdoor camps and/or programs.

General exclusions and limitations	
35	Services incident to or resulting from procedures for a surrogate mother, whether they are covered under the Plan or not (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Settlement of Disputes

Internal Appeals

Initial Internal Appeal

If you have received an Adverse Benefit Determination on a claim from the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may submit a request for an appeal to the Claims Administrator. Contact Customer Service via telephone or visit blueshieldca.com and include relevant information, such as:

- Your name;
- Member ID number;
- Date of service;
- Claim number;
- Provider name;
- Your explanation of what happened and why you believe the original determination was incorrect; and
- Any other supporting documents.

Transcarent Customer Service will directly assist you with submitting appeals to the Claims Administrator.

Written requests for initial internal appeal may be submitted to the following address:

Blue Shield of California
Attn: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Appeals must be submitted within 180 days after you receive notice of an Adverse Benefit Determination. The Claims Administrator will acknowledge receipt of an appeal within five calendar days. Appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator, unless qualified for an expedited decision.

Voluntary Second-Level Internal Appeal

You may request an external review immediately after the initial internal appeal determination by the Claims Administrator. However, you may choose a voluntary second-level internal appeal if you are dissatisfied with the initial internal appeal determination by the Claims Administrator. The determination may be appealed in writing to the Claims Administrator within 60 days after the date of receipt of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish the Claims Administrator to consider. The Claims Administrator shall notify you in writing of the results of its review and the specific basis therefor. In the event the Claims Administrator finds all or part of the appeal to be valid, the Claims Administrator, on behalf of the Employer, shall reimburse either you or your Health Care Provider for those expenses which the Claims Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 30 days

from the date of receipt to the Claims Administrator. Written requests for final internal standard appeals may be submitted to:

Blue Shield of California
Attn: Final Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Expedited Appeal (Initial and Voluntary Second-Level)

You have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including but not limited to severe pain or potential loss of life, limb or major bodily function. To initiate a request for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may call or write as instructed under the Initial and Voluntary Second-Level Internal Appeals sections outlined above. Specifically state that you want an expedited decision and that waiting for the standard processing might seriously jeopardize your health. The Claims Administrator will evaluate your request and medical condition to determine if it qualifies for an expedited decision. If it qualifies, your request will be processed as soon as possible to accommodate your condition, not to exceed 72 hours.

External Review

Standard External Review

If you are dissatisfied with the initial internal appeal determination or voluntary second-level internal appeal determination, and the determination involves medical judgment, a rescission of coverage, or consideration of whether the Plan is complying with surprise billing and cost-share protections under the federal No Surprises Act, you, a designated representative, a provider or an attorney on your behalf, may request an external review with an Independent Review Organization.

Requests for external review must be submitted within four months after notice of the initial internal appeal determination, or, if applicable, within four months after notice of the voluntary second-level internal appeal determination. The Independent Review Organization will provide a determination within 45 days after the Independent Review Organization receives the request for the external review. Instructions for submitting a request for external review will be outlined in the final internal appeal response letter.

Expedited External Review

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within four months from the Adverse Benefit Determination without participating in the initial or final internal appeal process.

To initiate a request for an expedited external review, you, a designated representative, a provider or an attorney on your behalf may fax a request to (844) 696-6071, or write to the following address. Specifically state that you want an

expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

Blue Shield of California
Attn: Expedited External Review
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Binding Arbitration

A dispute regarding a claim for Benefits, including Prescription Drug Benefits administered as a Covered Service, must proceed first through the claims process described in this section above before any further legal action can be taken with respect to that claim. Otherwise any dispute or claim, of whatever nature, including a claim for Benefits that has completed the internal appeals process, that arises out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court.
Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

The Member and UC agree to be bound by this binding arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

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

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

The arbitration is begun by the Member making written demand on UC. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and UC, or by order of the court, if the Member and UC cannot agree that has completed the internal appeals process.

Other important information about your Plan

This section provides legal and regulatory details that impact your health care coverage. This information is a supplement to the information provided in earlier sections of this document.

Your coverage, continued

Special enrollment period

For more information about special enrollment periods, see ***Special enrollment period*** on page 41 in the ***Your coverage*** section.

A special enrollment period is a timeframe outside of open enrollment when an eligible Participant or Dependent can enroll in, or change enrollment in, a health plan. The special enrollment period is 30 days following the date of a Qualifying Event except as otherwise specified below. The following are examples of Qualifying Events. For complete details and a determination of eligibility for special enrollment, please consult your Employer.

- Loss of eligibility for coverage, including the following:
  - The eligible Employee or Dependent loses coverage under another employer health benefit plan or other health insurance and meets all of the following requirements:
    - The Employee or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time the Employee was initially offered enrollment under this Plan;
    - If required by the Employer, the Employee certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment provided that the Employee was given notice that such certification was required and that failure to comply could result in later treatment as a Late Enrollee;
  - The Employee or Dependent was eligible for coverage under Medicaid (e.g. Healthy Families Program or Medi-Cal) and such coverage was terminated due to loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage;
  - The eligible Employee or Dependent loses coverage due to legal separation, divorce, loss of dependent status, death of the Employee, termination of employment, or reduction in the number of hours of employment;
  - In the case of coverage offered through an HMO, loss of coverage because the eligible Employee or Dependent no longer resides, lives, or works in the service area (whether or not within the choice of the

individual), and if the previous HMO coverage was group coverage, no other benefit package is available to the Employee or Dependent;
    - Termination of the employer health plan or contributions to Employee or Dependent coverage;
    - Exhaustion of COBRA group continuation coverage; or
- The Employee or Dependent is eligible for coverage under a Medicaid (e.g. Healthy Families Program or Medi-Cal) premium assistance program, provided that enrollment is within 60 days of the notice of eligibility for these premium assistance programs;
- A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child effective the first day of the month following presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party or the Employer, as described in Section 3751.5 and 3766 of the Family Code; or
- An eligible Employee acquires a Dependent through marriage, establishment of domestic partnership, birth, or placement for adoption. Applies to both the Employee and the Dependent.

Out-of-area services

Overview

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Programs and they operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members receive Covered Services outside of California, the claims for those services may be processed through one of these Inter-Plan Programs described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), members generally obtain care from healthcare providers that have a contractual agreement ("Participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("Non-participating providers") with the Host Blue. The Claims Administrator's payment practices for both kinds of providers are described below and in the *Introduction* section of this Benefit Booklet.



See the ***Care outside of California*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Inter-Plan Programs

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard® Program

Under the BlueCard® Program, benefits will be provided for Covered Services received outside of California, but within the BlueCard® Service Area. When you access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what we agreed to in the Benefit Booklet. However, the Host Blue is responsible for handling all interactions with its providers, including contracting with participating healthcare providers, including direct payment to the provider.

The BlueCard® Program enables you to obtain Covered Services outside of California, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment, Coinsurance and Deductible amounts, if any, as stated in this Benefit Booklet.

The Claims Administrator calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this Benefit Booklet. Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard® Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

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

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to your provider. Sometimes, it is an estimated price that considers special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, consider adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the Claims Administrator used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods,

including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard® providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at bcbs.com and select "Find a Doctor."

Prior authorization may be required for non-emergency services. Please see the *Utilization Management Program* section for additional information on prior authorization and the *Emergency Benefits* section for information on emergency admission notification.

Non-participating providers outside of California

When Covered Services are provided outside of California and within the BlueCard® Service Area by non-participating providers, the amount a Member pays for such services will be based on either the Host Blue's non-participating healthcare provider local payment, the Allowable Amount the Claims Administrator pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state or federal law. In these situations, the Member will be responsible for any difference between the amount that the non-participating provider bills and the payment the Claims Administrator will make for Covered Services as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law

If you do not see a participating provider through the BlueCard® Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Claims Administrator for reimbursement. The Claims Administrator will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Your Cost Share for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Services as listed in the *Summary of Benefits*.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please see the *Utilization Management Program* section for additional information on emergency admission notification.

Blue Cross Blue Shield Global® Core (Blue Shield Global® Core)

Care for Covered Services outside the BlueCard Service Area

The Blue Cross and Blue Shield Association, of which the Claims Administrator is a member, has a program called Blue Cross Blue Shield Global® Core (Blue Shield Global® Core). If you are outside of the

BlueCard® Service Area, you may be able to take advantage of Blue Shield Global® Core when accessing a network of inpatient, outpatient, and professional services. Blue Shield Global® Core is unlike the BlueCard® Program available within the BlueCard® Service Area in certain ways. For instance, although Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from provider outside the BlueCard® Service Area, you will typically have to pay the providers and submit the claim yourself to obtain reimbursement for these services. For Covered Services that are subject to your Plan's Deductible, you are also responsible for all costs up to the Allowable Amount until you reach your Deductible.

If you need assistance locating a doctor or hospital outside the BlueCard® Service Area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global® Core claim

When you pay directly for services outside the BlueCard® Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Customer Service, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to Covered Services from providers that participate in a Claims Administrator Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes, and Shared Savings arrangements.

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees

to the Claims Administrator through average pricing or fee schedule adjustments.

Limitation for duplicate coverage

Medi-Cal

Medi-Cal always pays for Benefits last when you have coverage from more than one payor.

Qualified veterans

If you are a qualified veteran, the Claims Administrator will pay the reasonable value or the Allowable Amount for Covered Services you receive at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, the Claims Administrator will pay the reasonable value or the Allowable Amount for Benefits you receive at a Department of Defense facility. This includes Benefits for conditions related to military service.

Coverage by another government agency

If you are entitled to receive Benefits from any federal or state governmental agency, by any municipality, county, or other political subdivision, your combined Benefits from that coverage and this Plan will equal but not be more than what the Claims Administrator would pay if you were not eligible for Benefits under that coverage. The Claims Administrator will provide Benefits based on the reasonable value or the Allowable Amount.

Exception for other coverage

An In-Network Provider may seek reimbursement from other third-party payors for the balance of their charges for services you receive under this Plan.

If you recover from a third party the reasonable value of Covered Services received from an In-Network Provider, the In-Network Provider is not required to accept the fees paid by the Claims Administrator as payment in full. You may be liable to the In-Network Provider for the difference, if any, between the fees paid by the Claims Administrator and the reasonable value recovered for those services.

Reductions – third-party liability/Subrogation

If your injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no Benefits will be payable or paid under the Plan unless you agree in writing, in a form satisfactory to the plan, to do all of the following:

- Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;
- Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery (defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from your own uninsured or underinsured motorist coverage;

- Execute a lien in favor of the Plan for the full amount of Benefits paid by the plan;
- Ensure that any Recovery is kept separate from and not comingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the plan;
- Periodically respond to information requests regarding the claim against the third party, and notify the plan, in writing, within 10 days after any Recovery has been obtained;
- Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If you fail to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the plan, through deductions from future benefit payments to you or others enrolled through you in the plan.

"Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the you or on your behalf, and without regard to whether you have been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in your name, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on your behalf, such as an attorney-client trust account.

You shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, you shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

Your acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys' fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys' fees and costs incurred in connection with the claims against the third party.

If you receive services from an In-Network Hospital for injuries or illness, the Hospital has the right to collect from you the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such services when you receive payment or reimbursement for medical expenses.

Coordination of benefits, continued

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by 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 an 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 us 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.

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. Benefits of This Plan cannot be determined until the Principal Plan has completed processing.
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 first of the following rules which applies will determine the order in which benefits are payable:

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

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

Medicare will pay second, and the plan which covers you as a retired employee would pay last.

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

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

   a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

   b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

      i. The plan which covers that child as a dependent of the parent with custody.

      ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

      iii. The plan which covers that child as a dependent of the parent without custody.

      iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

   c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. UC is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application

of this provision. In addition to the provisions outlined under Notice of Claim, a copy of the Other Plan Explanation of Benefits is required for coordination of benefits.

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 an Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

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

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, Blue Shield or this Plan 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.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

If you are entitled to Medicare, you will receive the full Benefits of this Plan, except as listed below:

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

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

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

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

1. Medicare must provide benefits first to any services covered both by Medicare and under this Plan.
2. For services you receive that are covered both by Medicare and under this Plan, coverage under this Plan will apply only to Medicare Deductibles, Copayments, and other charges for Covered Services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the Benefits provided under this Plan will not exceed the Maximum Allowed Amount for the Covered Services.

Blue Shield will apply any charges paid by Medicare for services covered under this Plan toward your Plan Deductible, if any.

These coordination of benefits rules do not apply to the programs included in the *Limitation for Duplicate Coverage* section.

General provisions

Independent contractors

Providers are neither agents nor employees of the Claims Administrator but are independent contractors. In no instance shall the Claims Administrator be liable for the negligence, wrongful acts, or omissions of any person providing services, including any Physician, Hospital, or other Health Care Provider or their employees.

Assignment

The Benefits of this Plan, including payment of claims, may not be assigned without the written consent of the Claims Administrator. In-Network Providers are paid directly by the Claims Administrator. When you receive Covered Services from an Out-of-Network Provider, the Claims Administrator, at its sole discretion, may make payment to the Participant or directly to the Out-of-Network Provider. If the Claims Administrator pays the Out-of-Network Provider directly, such payment does not create a third-party beneficiary or other legal relationship between the Claims Administrator and the Out-of-Network Provider. The Participant must make sure the Out-of-Network Provider receives the full billed amount, whether or not the Claims Administrator makes payment to the Out-of-Network Provider.

Plan interpretation

The Claims Administrator shall have the power and authority to construe and interpret the provisions of this Plan and to determine the Benefits of this Plan. University of California determines eligibility to receive Benefits under the Contract. The Claims Administrator shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Plan.

Access to information

The Claims Administrator may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Plan and the Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. Members also agree to assist the Claims Administrator in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the Claims Administrator with information in the Member's possession. Failure to assist the Claims Administrator in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by the Claims Administrator will be maintained as confidential and will not be disclosed without the Member's consent, except as otherwise permitted or required by law.

Right of recovery

Whenever payment on a claim is made in error, the Claims Administrator has the right to recover such payment from the Participant or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, the Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Participant (Cost Share or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant's coverage, or payments made on fraudulent claims.

Definitions

Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
Adverse Benefit Determination	A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for Benefits that is: • based on a determination of a Participant's or Dependent's eligibility to participate in the Plan; • resulting from the application of any utilization review; or • a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Allowable Amount	The maximum amount the Claims Administrator will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Benefit Booklet, the Allowable Amount is:
	• For an In-Network Provider: the amount that the provider and the Claims Administrator have agreed by contract will be accepted as payment in full for the Covered Service rendered.
	• For an Out-of-Network Provider who provides Emergency Services anywhere:
	  ○ Physicians and Hospitals: the amount is the Reasonable and Customary amount; or
	  ○ All other providers: (1) the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under federal law.
	• For an Out-of-Network Provider in California, who provides services other than Emergency Services:
	  ○ The amount the Claims Administrator would have allowed for an In-Network Provider performing the same service in the same geographical area but not exceeding any stated Benefit maximum;
	• Out-of-Network dialysis center: for services prior authorized by the Claims Administrator, the amount is the Reasonable and Customary amount.

	• For a provider outside of California but inside the BlueCard® Service Area, the lower of:
	  o The provider's billed charge, or
	  o The local Blue Plan's In-Network Provider payment or the pricing arrangement required by applicable state or federal law.
	• For a provider outside California and outside the BlueCard® Service Area, the amount allowed by Blue Shield Global® Core.
	For an Out-of-Network Provider outside of California (within the BlueCard® Service Area) that does not contract with a local Blue Cross and/or Blue Shield plan, who provides services other than Emergency Services: the amount that the local Blue Cross and/or Blue Shield plan would have allowed for an Out-of-Network Provider performing the same services. Or, if the local Blue Cross and/or Blue Shield plan has no Out-of-Network Provider allowance, the Allowable Amount is the amount for an Out-of-Network Provider in California. Or, if applicable, the amount determined under federal law.
	Where required under federal law the Allowable Amount used for purposes of determining your Cost Share may be based on the Plan's "qualifying payment amount," which may differ from the amount the Claims Administrator pays the Out-of-Network Provider or facility for Covered Services.

Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • Is a licensed facility accredited by an ambulatory surgery center accrediting body; and • Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital.
Behavioral Health Treatment (BHT)	Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. BHT includes applied behavior analysis and evidence-based intervention programs.
Benefits (Covered Services)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.

Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Care Coordinator	An individual within a provider organization who facilitates Care Coordination for patients.
Care Coordinator Fee	A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
Claims Administrator	The claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.
Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Deductible	The Calendar Year amount you must pay for specific Covered Services before the Claims Administrator pays for Covered Services pursuant to the Contract. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Deductible.
Dependent	The spouse, Domestic Partner, or child of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Participant.

	• A spouse who is legally married to the Participant and who is not legally separated from the Participant. • A Domestic Partner to the Participant who meets the definition of Domestic Partner as defined in this Benefit Booklet. • A child who is the child of, adopted by, or in legal guardianship of the Participant, spouse, or Domestic Partner, and who is not covered as a Participant. A child includes any stepchild, child placed for adoption, or any other child for whom the Participant, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Participant, spouse, or Domestic Partner), unless the Participant, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
Domestic Partner	An individual who is personally related to the Participant by a domestic partnership that meets all the following requirements: • Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code; • The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring; • The partners are: o not currently married to someone else or a member of another domestic partnership, and o not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited; • Both partners are capable of consenting to the domestic partnership; and • If required under your Plan Sponsor's eligibility requirements, provide a declaration of domestic partnership. The domestic partnership is deemed created on the date when both partners meet the above requirements.
Doula	Doulas are not medical providers. Doula training does not include clinical training. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and

	non-medical support for pregnant and postpartum persons before, during, and after childbirth. In order for Doulas to be covered, a Doula must be sanctioned to operate under another Health Care Provider's license.
Emergency Medical Condition	A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following: • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.
Emergency Services	The following services provided for an Emergency Medical Condition: • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; • Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and • Solely to the extent required under federal law, Emergency Services also include any additional items or services that are covered under the Plan and furnished by an Out-of-Network Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of

	outpatient observation or an inpatient or outpatient stay.
Employee	An individual who is a person classified by the University as an Employee, as defined in the UC Section 125 Plan, appointed and paid by the University. See UC Group Insurance Regulation Definitions Section.
Employer (Contractholder)	Is the University of California and is the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 (ERISA) as amended unless otherwise stated herein. For avoidance of doubt, while the definitions of Plan Sponsor and Plan Administrator are borrowed from ERISA, ERISA does not apply to this Plan. The Employer is responsible for funding the payment of claims for Benefits under the Plan.
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies shall be considered experimental or investigational if, as determined by Claims Administrator, at least one of the following elements is met: • Requires approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered; or • Is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use; or • Is not approved or recognized in accordance with accepted professional medical standards, but nevertheless is authorized by law or by a government agency for use in testing, trials, or other studies on human patients; or • Is not recognized or not recommended by nationally recognized treatment guidelines by a specialty society or medical review organization, if applicable, or where the consensus amongst experts in recognized published medical literature is that further studies or experience are necessary to determine effectiveness and net health benefit in treatment of the illness, injury, or condition at issue, but nevertheless are authorized by law or by a government agency for use.
Family	The Participant and all enrolled Dependents.

Former In-Network Provider	A Former In-Network Provider is a provider of services to the Member under any of the following conditions:
	• A provider who is no longer available to you as an In-Network Provider, but at the time of the provider's contract termination with the Claims Administrator, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former In-Network Provider* table in the *Continuity of care* section.
	• An Out-of-Network Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with the Claims Administrator became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former In-Network Provider* table in the *Continuity of care* section.
	• A provider who is an In-Network Provider with the Claims Administrator but no longer available to you as an In-Network Provider because:
	  ○ The Employer has terminated its contract with the Claims Administrator; and
	  ○ The Employer currently contracts with a new health plan (insurer) that does not include the Claims Administrator In-Network Provider in its network; and
	  ○ At the time of the Employer's contract termination you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former In-Network Provider* table in the *Continuity of care* section.

Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist;

	• Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Registered dietician; • Registered nurse; • Registered respiratory therapist; • Speech and language pathologist.
Hemophilia Home Infusion Provider	A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia. An In-Network home infusion agency may not be an In-Network Hemophilia Infusion Provider if it does not have an agreement with the Claims Administrator to furnish blood factor replacement products and services.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Hospital	An entity that meets one of the following criteria: • A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.

Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area.
Independent Review Organization	An entity that conducts independent external reviews of Adverse Benefit Determinations.
Infertility	May be either of the following: • A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or • The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.
In-Network Hospice or In-Network Hospice Agency	An entity that has either contracted with the Claims Administrator or has received prior approval from the Claims Administrator to provide Hospice service Benefits.
In-Network (In-Network Provider)	A provider who participates in this Plan's network and contracts with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as a Blue Shield PPO Provider.
Intensive Outpatient Program	An outpatient treatment program for Mental Health Conditions or Substance Use Disorder Conditions that provides structure, monitoring, and medical/psychological intervention for nine to nineteen hours a week.
Inter-Plan Programs	The Claims Administrator's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Late Enrollee	An eligible Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 90 days from the date a written request for coverage is made or at the Employer's next open enrollment period.
Medical Necessity (Medically Necessary)	Benefits are provided only for services that are Medically Necessary. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by the Claims Administrator, are:

	• Consistent with the Claims Administrator's medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician's office, the Outpatient Department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient admission is not Medically Necessary for certain services, including, but not limited to, the following: • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and • Inpatient rehabilitation that can be provided on an outpatient basis. The Claims Administrator reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.
Member	An individual who is enrolled and maintains coverage in the Plan pursuant to the Plan Document as either a Participant or a Dependent. Use of "you" in this document refers to the Member.
Mental Health Condition	Mental health disorders that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental Health Services	Services provided to treat a Mental Health Condition.
Other Outpatient Mental Health and Substance Use Disorder Services	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions, including but not limited to the following: • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy; • Office-based opioid treatment; • Transcranial magnetic stimulation; • Neuropsychological and Psychological Testing; and • Behavioral Health Treatment. These services may also be provided in the office, home, or other non-institutional setting.
Out-of- Network (Out-of-Network Provider)	Any provider who does not participate in this Plan's network and does not contract with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services. Certain services of this Plan are not covered or benefits are reduced if the service is provided by an Out-of-Network Provider.
Out-of-Pocket Maximum	The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the *Summary of Benefits* section. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.
Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services that are at a minimum 20 hours per week.
Participant	An individual who is eligible to receive benefits pursuant to the UC Group Insurance Regulations and is enrolled in the plan.

Premium Contribution	Amounts the Plan Sponsor may require Participants to contribute toward the cost of coverage under the Plan.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Plan	the HealthSavings+ Benefit Plan for eligible Employees of the Employer.
Plan Administrator	Is University of California.
Plan Document	The document adopted by the Plan Sponsor that establishes the services that Participants and Dependents are entitled to receive under the Plan.
Plan Sponsor	Is University of California.
Plan Year	The calendar year, beginning January 1 through December 31.
Preventive Health Services	Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the *Preventive Health Services* section.
Primary Care Physician (PCP)	A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician.
Provider Incentive	An additional amount of compensation paid to a Health Care Provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
Neuropsychological and Psychological Testing	Testing to diagnose a Mental Health Condition and/or to assess the health of certain brain functions when referred by a provider providing Mental Health and Substance Use Disorder Benefits.
Reasonable and Customary	In California: The lower of (1) the provider's billed charge, (2) the amount determined by the Claims Administrator to be the reasonable and customary value for the services rendered by an Out-of-Network Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered, or (3) if applicable, the amount determined under federal law.

	Outside of California: The lower of (1) the provider's billed charge, or, (2) if applicable, the amount determined under federal law.
Reconstructive Surgery	Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: • Improve function; or • Create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures.
Skilled Nursing	Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse.
Skilled Nursing Facility (SNF)	A health facility or a distinct part of a Hospital with a valid license issued by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis.
Specialist	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and • Other designated as appropriate.
Subacute Care	Skilled Nursing or skilled rehabilitation provided in a hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A

	facility that is primarily a rest-home, convalescent facility, or home for the aged is not included.
Substance Use Disorder Condition	Substance Use disorders that fall under the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) or that are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Substance Use Disorder Services	Services provided to treat a Substance Use Disorder Condition.
Total Disability (Totally Disabled)	In the case of an Employee, or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity. In the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Notices about your Plan

Notice about high deductible health plans: This Plan is intended to qualify as a high deductible health plan (HDHP) that meets the requirements of Section 223 of the Internal Revenue Code of 1986, as amended. It is designed to be compatible for use with tax-favored health savings accounts established under federal tax law. If this Plan no longer qualifies as an HDHP, the Claims Administrator will make efforts to amend this Plan to meet the qualifications. If there is a change in plan provisions, the Claims Administrator will provide written notice of the change, and the change shall become effective on the date provided in the written notice.

This Plan is not a "Health Savings Account" or an "HSA", but is designed as a "high deductible health plan" that may allow you, if you are eligible, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this Plan. If this Plan was selected in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible

The Claims Administrator does not provide tax advice. If you have questions about health savings accounts or other tax-favored arrangements that are compatible with HDHPs under federal law, you should consult with your tax advisor.

Notice about this Administrative Services Only plan: The Plan Document is on file with your Employer and a copy will be furnished upon request.

University of California is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Notice about Plan Benefits: Benefits are only available for services and supplies you receive while covered by this Plan. You do not have the right to receive the Benefits of this Plan after coverage ends, except as specifically provided under the *Continuity of care* and *Continuation of group coverage* sections. The Claims Administrator may change Benefits during the term of coverage as specifically stated in this Benefit Booklet. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

Notice about Medical Necessity: Benefits are only available for services and supplies that are Medically Necessary. The Claims Administrator reserves the right to review all claims to determine if a service or supply is Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your Plan and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or contact Customer Service to ensure that you can obtain the health care services you need.

Notice about In-Network Providers: The Claims Administrator contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual agreement may include incentives to manage all services for Members in an appropriate manner consistent with the Plan. To learn more about this payment system, contact Customer Service.

Notice about confidentiality of personal and health information: The Claims Administrator protects the confidentiality/privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. The Claims Administrator will not disclose this information without authorization, except as permitted by law.

A STATEMENT DESCRIBING THE CLAIMS ADMINISTRATOR'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

The Claims Administrator's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling Customer Service or by visiting member.transcarent.com or blueshieldca.com.

Members who are concerned that the Claims Administrator may have violated their privacy rights, or who disagree with a decision the Claims Administrator made about access to their individually-identifiable personal information, may contact the Claims Administrator at:

Blue Shield of California Privacy Office
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

Notice about 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 Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for prior authorization; and
- 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 Share (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 Allowable 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 Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network Benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for the Out-of-Network Cost Share for those services and the Out-of-Network Provider can also charge you any difference between the maximum Allowable Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) intensivists; and (J) any services set out by the U.S.

Department of Health & Human Services. In addition, The Claims Administrator will not apply this notice and consent process to you if the Claims Administrator does not have an In-Network Provider in your area who can perform the services you require. 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.

How Cost Share is Calculated

Your Cost Share for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that the Claims Administrator pays In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket Cost Share you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Maximum.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility 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 "Settlement of Disputes" 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 the In-Network Cost Share (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network Cost Share will be calculated based upon the maximum Allowable 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.

Notice about your UC Plan: By authority of the Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations for Faculty and Staff, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their Human Resources Office and retirees should call the Retirement Administration Service Center (800-888-8267).

In conformance with applicable law and University policy, the University is an equal opportunity employer. Please send inquiries regarding the University's equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607, and for faculty to the Office of Academic Personnel and Programs, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Shield of California:

Provides aids and services at no cost to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (including large print, audio, accessible electronic formats and other formats)

Provides language services at no cost to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language access services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。
無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل بالتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

Family Building Plan Design- Cycle Lifetime Benefit

University of California Family Building Benefit will include up to Two (2) "Cycles" of IVF-Egg Retrievals as lifetime maximum (LTM) of this membership for *Eligible Covered Members.*

The member is encouraged to enroll and services must be preauthorized by calling the WIN Medical Management Program at least two weeks prior to the initiation of hormone treatment services.

Failure to obtain authorization of services will result in a claims denial of benefits.

The fertility benefit is available to all employees and their dependents enrolled in the University of California non-Medicare PPO plans. Cost share (copay, coinsurance, deductible) of the PPO plans' infertility benefit will apply to the services discussed in this document. For more information, please see your UC PPO medical plan documents by visiting this website: http://ucal.us/facultystaffppo.

Infertility Services Network
WINFertility administers a **dedicated network of infertility providers** for UC members. This network is considered **in-network** for infertility services under your UC PPO plan. Not all infertility providers participate in the WINFertility network.

Members are strongly encouraged to receive infertility care from **WINFertility-contracted providers** to ensure the highest level of benefit coverage and minimize out-of-pocket expenses. When services are received from WINFertility-contracted providers, payment is based on **negotiated (allowed) charges**, and members are responsible only for applicable copayments, coinsurance, or deductibles.

If you choose to receive infertility services from a **non-contracted provider**, the provider may bill charges that
exceed the plan's allowed amount. In such cases, you are responsible for **the difference between the billed charge and the allowed charge**, in addition to any plan benefit cost sharing (deductibles, copays, and coinsurance).

To locate a WINFertility-contracted provider or for assistance with infertility services, contact **WINFertility** at **(877) 451-3077**.

Infertility Medications
Infertility-related medications are **only covered via Plan benefits when obtained via WINFertility's mail order pharmacy**. These prescriptions are coordinated through your **WINFertility Nurse Care Manager** and the **WINFertility Pharmacy** to ensure timely delivery and proper management of your treatment plan.

When obtained through other mail order or retail pharmacies, infertility medications are **not covered** under your UC plan benefits.

For more information or assistance with obtaining infertility medications, please contact **WINFertility** at **(877) 451-3077**.

DIAGNOSIS OF INFERTILITY REQUIRED FOR ALL INFERTILITY RELATED SERVICES: The fertility benefit is available to all employees and their dependents with a diagnosis of infertility.

Covered Services for the Two (2) IVF Cycle Lifetime Maximum Benefit Include:

1) Diagnostic services for fertility not covered by another source
2) Artificial insemination (AI) cycles and timed intercourse cycles
   a) Natural cycles
   b) Oral ovulation induction cycles (clomiphene citrate/letrozole)
   c) Gonadotropin/menotropin cycles only if member has failed three (3) oral ovulation induction cycles or member has diagnosis of hypogonadotropic anovulatory disorders or hypopituitarism
3) The following Assisted Reproductive Treatment (ART) cycles and procedures are covered:
4) In-Vitro Fertilization (IVF) –Egg Retrieval limited to two (2) per lifetime
5) Donor IVF cycle – Recipient Portion Only
6) Assisted Hatching
7) Oocyte Thaw Cycles (OTC)
8) Frozen Embryo Transfer (FET)
9) Gamete Intrafallopian Cycle (GIFT)
10) Zygote Intrafallopian Transfer (ZIFT)
11) Preimplantation Genetic Testing with Embryo Biopsy when the following criteria is met:
   a) Oocyte from member that is age 35 or older
   b) Recurrent Pregnancy Loss (two or more unexplained clinical pregnancy losses) or previously diagnosed aneuploid pregnancies or births
   c) Recurrent implantation failure (three or more failed embryo transfers)
   d) Both parents are carriers of a recessive single gene autosomal mutation
   e) One parent is a known carrier of a single gene autosomal dominant or X-linked disease.
   f) One parent is a known translocation carrier
12) Cryopreservation of blastocysts(s) and embryo(s) from covered IVF and OTC cycles with storage for up to one (1) year from the date of the initial cryopreservation.
13) Oocyte cryopreservation cycles including one year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes)
14) Sperm cryopreservation including one year of storage from the initial date of cryopreservation when a medical treatment will directly or indirectly lead to iatrogenic infertility (an impairment of fertility by surgery, radiation, chemotherapy,

or other medical treatment affecting reproductive organs or processes
15) Pathology and laboratory services, including but not limited to:
    a) Hormonal assays
    b) Semen analysis, as appropriate
    c) Ultrasound exams
    d) Fertilization and appropriate embryology services
    e) Ova identification
16) Male Surgical Procedures for fertility not covered by another source subject to LTM
    a) PESA, MESA, TESE, or Varicocele repair would use one (1) cycle
17) Medications necessary to the provisions above, including parenteral injection, are included for infertility treatment related drugs while the member is a member of this plan and until exhaustion of benefit.

Benefit Specifics:

The member < 35 years old should use all frozen embryos (or all euploid frozen embryos, if PGS was performed) before moving to a new IVF Cycle (oocyte retrieval); however, exceptions can be made if coverage is for a fertility preservation cycle, the member paid OOP for their cycle, or another insurance plan covered the cycle in which the embryos were created.

A "cycle" is defined by this plan as ovarian stimulation with egg(s) retrieval. Member's will have coverage for two (2) egg retrieval cycles with fertilization of eggs and subsequent embryo transfer for all embryos created from a covered cycle. A cycle will be considered "completed" once any retrieval service or episode has occurred, whether or not the resulting retrieval service or episode results in any embryos for transfer, or a successful pregnancy is achieved.

Note: Once a member has completed Two (2) "cycles" of IVF-Egg Retrievals, the lifetime benefit maximum has been reached for all infertility related services, including Intrauterine Insemination (IUI) services.

EXCLUSIONS:
The following services are excluded from coverage:

a. DONOR EXPENSES.
    a. **DONOR NOT COVERED:** Related donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g., suppression medications, stimulation medications).

b. VOLUNTARY STERILIZATION EXCLUSION
    a. **DOI REQUIRED**: If a member has undergone an elective sterilization procedure, they are not eligible for benefits unless they undergo a successful reversal and thereafter met DOI; Or WIN's consulting medical

director determines that the reversal of the elective sterilization procedure is not medically indicated or will not improve the likelihood of conception due to multifactorial causes of infertility. Reversal of a sterilization procedure is not covered.

c. Surrogacy /Gestational Carriers and any fees associated with it are not covered under the fertility benefit, please refer to the Adoption and Surrogacy reimbursement benefit. However, note that the medical expenses for any of the member's portion of a treatment cycle is covered even if they are using a surrogate/gestational carrier.
d. Services not specifically listed as covered.
e. Artificial Insemination or Timed Intercourse cycles stimulated with Gonadotropin or menotropin (e.g. FSH/IUI cycles) are excluded unless member has diagnosis of hypogonadotropic anovulatory disorders or hypopituitarism, or after member has not ovulated or conceived after a prior trial of 3 cycles of clomiphene citrate or letrozole.
f. Cost share (copays and coinsurance) for services covered under your UC PPO health plan benefit are excluded.

(Intentionally left blank)