LANS

Benefit Program Summary

Effective June 1, 2006

Core NM Plan
(BlueCard)

Without Medicare

IMPORTANT

This is a summary of highlights of the above-named Benefit Program, a component of the LANS Welfare Benefit Plan for Employees, ERISA Plan 501 and the LANS Welfare Benefit Plan for Retirees, ERISA Plan 502 (each a "Plan"). Receipt of this document and/or your participation in a Plan and any benefit programs under a Plan do not guarantee your employment or any rights or benefits under a Plan. LANS reserves the right to amend or terminate each Plan or any benefit program(s) under a Plan at any time. Each Plan and the benefit programs referred to in this summary are governed by a Federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries. This is a change from the status of benefits provided by the University of California, which may have been subject to the "vested rights doctrine" or similar doctrines, which limit certain benefit plan changes.

For more information on LANS benefit programs, see the LANS Welfare Benefit Plan for Employees Summary Plan Description or the LANS Welfare Benefit Plan for Retirees Summary Plan Description, as applicable, available from the Los Alamos National Laboratory (LANL) Benefits Office at (877) 667-1806 or (505) 667-1806.

Dear Member*:*

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

Subscribers and covered family members ("*members*") are referred to in this booklet as "you" and "your". "We", "us" and "our" refer to the Benefit Program.

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

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

In addition to the information contained in this Benefit Program Summary, the LANS Welfare Benefit Plan for Employees Summary Plan Description or the LANS Welfare Benefit Plan for Retirees Summary Plan Description, as applicable, contains important information about your LANS welfare benefits. This Benefit Program is a part of the LANS Summary Plan Description ("SPD"). The LANS SPD applicable to you depends on whether you are an employee or a retiree and is referred to in this Benefit Program Summary as "your LANS SPD."

For additional information:

For Retirees:

Customer Care Center
(866) 934-1200
www.ybr.com/benefits/lanl

LANL Benefits Website for Retirees:
http://www.lanl.gov/worklife/benefits/retirees/

For Employees:

Los Alamos National Laboratory (LANL)
LANL Benefits Office
P.O. Box 1663, Mail Stop P280
Los Alamos, NM 87544
(877) 667-1806 or (505) 667-1806
Email: **benefits@lanl.gov**

LANL Benefits Website for Employees:
http: //int.lanal.gov/worklife/benefits/

TABLE OF CONTENTS

LANS - CORE NM Plan
without Medicare

BENEFITS AT A GLANCE

This is a brief review of your benefits. For complete information, including the terms and conditions of this Benefit Program and exclusions and limitations, please refer to the entire Benefit Program Summary.

Calendar year deductible for all providers:	$3,000/member
Penalty for not obtaining preauthorization where required:	$500/admission
Annual out-of-pocket maximums for all providers:	$7,600/member/year

The following do not apply to out-of-pocket maximums: non-covered expenses, costs in excess of the covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-compliance penalties, and for non-PPO and other health care provider costs in excess of the covered expense.

Lifetime Maximum	$2,000,000/member

Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay**
Hospital Medical Services *(preauthorization required for non- emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	20%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	20%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	
Skilled Nursing Facility		
➢ Semi-private room, services & supplies *(limited to 120 days/calendar year)*	20%	
Urgent Care (Freestanding)	20%	20%
Hospice Care		
➢ Inpatient or outpatient services for members with up to one year life expectancy *(Lifetime benefit of 30 days inpatient/$5,000 outpatient)*	20%	
Home Health Care		
➢ Services & supplies from a home health agency *(limited to combined maximum of 100 visits/calendar year, one visit by home health aide equals four hours or less; not covered while member receives hospice care)*	20%	
Registered Special Duty Nurse *(outpatient only; limited to $10,000/calendar year)*	20%	20%
Home Infusion Therapy	20%	
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services		
Physician Medical Services		
➢ Office & home visits	20%	20%
➢ Hospital & skilled nursing facility visits	20%	20%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	20%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Diagnostic X-ray & Lab *(including mammograms, Pap smears, & prostate cancer screenings)*	20%	
Radiation Therapy, Chemotherapy, & Hemodialysis Treatment	20%	20%
Preventive Care		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	20%	20%
➢ Vision Exams *(when medically necessary)*	20%	20%
➢ Hearing Exams & Hearing Aids	Not covered	Not covered
➢ Allergy testing & treatment *(including serums)*	20%	20%
Physical Therapy, Physical Medicine & Occupational Therapy	20%	20%
Chiropractic Services	20%	20%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	20%	20%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to $500/calendar year maximum)*	20%	20%
Temporomandibular Joint Disorders *(preauthorization required*)		
➢ Splint therapy & surgical treatment	20%	20%
Family Planning Services		
➢ Infertility studies & tests	20%	20%
➢ Tubal ligation	20%	20%
➢ Vasectomy	20%	20%
➢ Counseling & consultation	20%	20%
➢ Elective abortion	20%	20%
Pregnancy & Maternity Care		
➢ Physician office visits	20% *(deductible waived)*	20%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	20%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered)*		
➢ Inpatient physician services	20%	20%
➢ Hospital & ancillary services	20%	20%
Organ & Tissue Transplants *(preauthorization required)*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	20%
➢ Physician office visits *(including specialists and consultants)*	20%	20%
➢ Transplant travel expense for an authorized, specified transplant at an approved transplant center *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	20%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery	20%	20%
Durable Medical Equipment		
➢ Rental or purchase of DME including dialysis equipment & supplies, & medically necessary therapeutic shoes and inserts	20%	20%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%	20%
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%	20%
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%	20%
Emergency Care		
➢ Emergency room services & supplies	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%
Outpatient Drugs and Medications		
➢ Drugs and medications, including oral contraceptives & insulin, when dispensed by a physician or licensed pharmacist	20%	

Mental and Nervous Disorders & Substance Abuse Benefits are not covered.

Members **residing outside of the PPO service area will be responsible for 20% of the Customary & Reasonable allowance plus the difference between the Customary & Reasonable allowance and billed charges.**

Members **traveling out of the country will be responsible for 20% of the billed charges.**

LANS BENEFIT PROGRAM SUMMARY

JUNE 1, 2006

We encourage you to review your Benefit Program Summary carefully. You should also carefully read your LANS SPD.

ELIGIBILITY

If the Plan is a Point-of-Service (POS) or Exclusive Provider Organization (EPO) Plan, employees are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-LANS Medicare Advantage Managed Care contract or enrolled in a non-LANS Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscribers

Information about employee eligibility can be found in your LANS SPD

Eligible Dependents (Family Members)

Information about dependent eligibility can be fund in your LANS SPD.

More Information

For information on who qualifies and how to enroll is available:

For Retirees:
Customer Care Center
(866) 934-1200
www.ybr.com/benefits/lanl

For Employees:
LANL Benefits Office
(877) 667-1806 or (505) 667-1806
www.int.lanl.gov/worklife/benefits/

ENROLLMENT

Information about the enrollment process can be found in your LANS SPD.

Period of Initial Eligibility (PIE)

Information about your PIE can be found in your LANS SPD.

At Other Times For Retirees

Information about other opportunities to enroll can be found in your LANS SPD.

Effective Date

Information about when coverage begin and ends can be found in your LANS SPD.

Change in Coverage

Information about changes in coverage can be found in your LANS SPD.

Effect of Medicare on Retiree Enrollment

Information can be found in your LANS SPD.

Medicare Secondary Payer Law (MSP)

Information can be found in your LANS SPD.

MEDICARE PRIVATE CONTRACTING PROVISION AND PROVIDERS WHO DO NOT ACCEPT MEDICARE

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by LANS (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by LANS in accordance with its SPD are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

See your LANS SPD for additional information.

Deenrollment Due to Fraud

See your LANS SPD for additional information.

Leave of Absence, Layoff or Retirement

Contact the LANL Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

Information can be found in your LANS SPD.

PLAN ADMINISTRATION

Please refer to your LANS SPD for more information.

Administration of the Plan

The Benefits and Investment Committee is the plan administrator for the Benefit Program described in this Benefit Program Summary. If you have a question, you may direct it to:

Benefits and Investment Committee
TA-3 Building 261
2nd Floor
Los Alamos, NM 87545

Mailing Address:

Benefits and Investment Committee
P.O. Box 1663, Mail Stop P280
Los Alamos, NM 87544

Claims under the Plan are processed by BC Life & Health Insurance Company at the following address and phone number:

BC Life & Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-007

BC Life's Customer Service number is (800) 759-3030

Group Case Number. The Group Case Number for this Benefit Program is: 175172

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers. There are two kinds of *participating providers* in this *benefit program:*

- **PPO Providers** are primarily *hospitals* and *physicians* who participate in a BlueCard PPO network and have agreed to provide PPO members with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers.
- **Traditional Providers** are providers who might not participate in a BlueCard PPO network, but have agreed to provide PPO members with health care services at a discounted rate.

The level of benefits we will pay under this *benefit program* is determined as follows:

- If your *benefit program* identification card (ID card) shows a PPO suitcase logo and:
  - You go to a PPO Provider, you will get the higher level of benefits of this *benefit program*.
  - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this *benefit program*.
- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this *benefit program*.

Please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in your area. A directory of PPO Providers is available. You can get a directory from your plan administrator (usually your employer).

Non-Participating Providers. *Non-participating providers* are *hospitals* and *physicians* which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the *negotiated rates* and other provisions.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *Benefit Program Summary*. This doesn't mean they can provide every service that a medical doctor could; it just means that we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor.

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

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

SUMMARY OF BENEFITS

THE BENEFITS OF THIS BENEFIT PROGRAM ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS A COVERED EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS *BENEFIT PROGRAM SUMMARY* CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

This summary provides a brief outline of your benefits. You need to refer to the entire *benefit program summary* for complete information about the benefits, conditions, limitations and exclusions of your *benefit program*.

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

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

The benefits of this *benefit program* may be subject to third party reimbursement as discussed in your LANS SPD.

IMPORTANT NOTICE ABOUT YOUR MEDICAL BENEFITS

Your *benefit program* has Utilization Review Program and Authorization Program requirements. These are explained in the Medical Management section beginning on page 32. **Your benefits may be reduced** if you do not follow the procedures outlined. If you have any questions about the Utilization Review Program or Authorization Program requirements, call the *claims administrator's* toll-free number on your identification card.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductible (Per *Member*).....**$3,000**

Exceptions:

-- The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating provider* if those visits are for pregnancy or maternity care. **Note:** This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

-- The Calendar Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.

Non-Certification Deductible.....**$ 500**

Exception: The Non-Certification Deductible will not apply to *emergency* admissions. See MEDICAL MANAGEMENT PROGRAMS.

CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

Co-Payments. After you have met your Calendar Year Deductible, you will be responsible for **20%** of *covered expense* you incur, plus any amount in excess of *covered expense*.

Exception: No Co-Payment will be required for the transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

Out-of-Pocket Amount. After you have made **$7,600** in total out-of-pocket payments for *covered expense* you incur during a *calendar year,* you will no longer be required to pay a Co-Payment for the remainder of that *year,* but you remain responsible for costs in excess of *covered expense*.

Exceptions: Medical Management Program penalties, expenses which are incurred for non-covered services or supplies, or which are in excess of the amount of *covered expense,* will not be applied toward your Out-of-Pocket Amount, and are always your responsibility.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

- For covered *skilled nursing facility* care..... **120 days** per *calendar year*

Home Health Care

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

Hospice Care

- For inpatient *hospice* care..... **30 days** during your lifetime

- For outpatient *hospice* care
  (including bereavement counseling).....**$5,000**
  during your lifetime

Private Duty Nursing

- For covered private duty nursing services.....**$10,000**
  per *calendar year*

Acupuncture Treatment

- For covered services.....**$500**
  per *calendar year*

Transplant Travel Expense

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

Lifetime Maximum

- For all medical benefits **$2,000,000**
  during your lifetime

IMPORTANT NOTE

MEMBERS RESIDING OUTSIDE OF THE PPO SERVICE AREA WILL BE RESPONSIBLE FOR **20%** OF THE CUSTOMARY & REASONABLE ALLOWANCE PLUS THE DIFFERENCE BETWEEN THE CUSTOMARY & REASONABLE ALLOWANCE AND BILLED CHARGES.

MEMBERS TRAVELING OUT OF THE COUNTRY WILL BE RESPONSIBLE FOR **20%** OF THE BILLED CHARGES.

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

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

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

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

Note: If an *other health care provider* is participating in a Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a *participating provider* for the purposes of determining *covered expense*.

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

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

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

1. By a *hospital,* in excess of the approved amount as determined by Medicare; or
2. By a *physician* or *other health care provider,* in excess of the lesser of the maximum *covered expense* stated above, or:
    a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
    b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

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

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

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

DEDUCTIBLES

Each deductible under this *benefit program* is separate and distinct from the other. Only charges that are considered *covered expense* will apply toward satisfaction of any deductible.

Calendar Year Deductible. Each *year*, you will be responsible for satisfying the Calendar Year Deductible before the *benefit program* begins to pay benefits.

CO-PAYMENTS

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

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

OUT-OF-POCKET AMOUNT

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

Charges Which Do Not Apply Toward the Out-Of-Pocket Amount. The following expense will not be applied toward satisfaction of an Out-Of-Pocket Amount and is always your responsibility:

- Medical Management Program penalties that may apply;
- Expense which is incurred for non-covered services or supplies; and
- Expense which is in excess of the amount of *covered expense.*

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *benefit program* will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by us.

CONDITIONS OF COVERAGE

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

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

MEDICAL CARE THAT IS COVERED

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

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless the *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*.

2. Services in *special care units*.

3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 120 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. *Medically necessary* supplies provided by the *home health agency*.

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

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

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.

8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

Plan benefits are limited to a lifetime maximum of 30 days of inpatient care and **$5,000** for outpatient care.

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

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

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

3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

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

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

Outpatient Private Duty Nursing. We will pay up to **$10,000** per *calendar year* for private duty nursing services of a licensed nurse (R.N., L.P.N. or L.V.N.) for a non-hospitalized acute illness or injury, provided your *physician* orders the services as *medically necessary*.

"Private duty" means a session of four or more hours that continuous nursing care is furnished to you alone.

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

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

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.

2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.

4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

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

Diagnostic Services. Outpatient diagnostic radiology and laboratory services.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.

2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.

3. We will pay for other *medically necessary prosthetic devices,* including:

    a. Surgical implants;

    b. Artificial limbs or eyes; and

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

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Custom fitted orthotics that restrict or prevent the motion of a weak or diseased part of the body and *medically necessary* therapeutic shoes and inserts. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

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

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

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is enrolled under the *benefit program*.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a *member* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining prior authorization from the *claims administrator*, or which are provided at a facility other than an approved transplant center. See MEDICAL MANAGEMENT PROGRAMS.

Transplant Travel Expense. The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at an approved transplant center, provided the expenses are authorized by the *claims administrator* (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.):

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
    a. Round trip coach airfare to the transplant center, not to exceed **$250** per person per trip.
    b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
    c. Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
    a. Round trip coach airfare to the transplant center, not to exceed **$250**.
    b. Hotel accommodations, not to exceed **$100** per day for up to 7 days.
    c. Other expenses, such as meals, not to exceed **$25** per day, for up to 7 days.

Well Baby and Well Child Care (Dependent Children Under 19 Years of Age). The following services for a dependent *child* under 19 years of age:

1. *Physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations.
4. Vision screening for determining medical necessity of a vision examination.
5. Screening for blood lead levels as prescribed by a *physician*.

Preventive Care (Members Age 19 and Over). The following services for members age 19 years and over:

1. *Physician's* services for routine physical examinations.
2. Radiology and laboratory services in connection with routine physical examinations.
3. Vision screening for determining medical necessity of a vision examination.
4. Immunizations.

Allergy. Allergy testing and treatment, including serum.

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

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

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

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

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

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

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

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

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

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

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *benefit program*.

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

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

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

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

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.

Chiropractic Care. Chiropractic services for manual manipulation of the spine to correct subluxation demonstrated by *physician*-read x-ray.

Acupuncture. We will pay up to **$500** per *calendar year* for the services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.

Prescription Drugs and Medications. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*. The drugs or medicine must be dispensed by a *physician* or a licensed pharmacist. Also included are oral contraceptives, injectable insulin prescribed by a *physician*, and formulas prescribed by a *physician* for the treatment of phenylketonuria.

Family Planning. Family planning services, counseling and planning for problems of fertility and *infertility*, as *medically necessary*. Diagnosis and testing for *infertility*.

Infertility treatment, including GIFT, ZIFT, artificial insemination, in vitro fertilization, and any related laboratory procedures are not covered.

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

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

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

1. The following equipment and supplies:

    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

    b. Insulin pumps.

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

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

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

f. Alcohol swabs (no deductible, no copayment is required).

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

2. Diabetes education program which:

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

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

   c. Is supervised by a *physician*.

   Diabetes education services are covered as office visits to *physicians*.

3. The following medications and supplies:

   a. Insulin, glucagon, and other prescription *drugs* for the treatment of diabetes.

   b. Insulin syringes, disposable pen delivery systems for insulin administration.

   c. Testing strips and lancets.

   These items are covered as prescription drugs (see "Prescription Drugs and Medications").

Christian Science Benefits. The following provisions relate only to charges for Christian Science treatment:

1. A Christian Science sanatorium will be considered a *hospital* under the *benefit program* if it is accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

2. The term *physician* includes a Christian Science practitioner approved and accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Benefits for the following services will be provided when a *member* manifests symptoms of a covered illness or injury and receives Christian Science treatment for such symptoms.

1. Services provided by a Christian Science sanatorium if the *member* is admitted for active care of an illness or injury.

2. Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions of **MEDICAL CARE THAT IS NOT COVERED** apply equally to Christian Science benefits as to all other benefits and providers of care.

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

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a pharmacy and are covered as prescription drugs (see "Prescription Drugs and Medications"). Special food products that are not available from a pharmacy are covered as medical supplies under your *benefit program's* medical benefits.

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

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

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

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in “Injectable Drugs and Implants for Birth Control” provision in MEDICAL CARE THAT IS COVERED.

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

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

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

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

Education or Counseling. Educational services, or nutritional counseling, except as specifically provided or arranged by us, or as stated under the "Diabetes" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Food or dietary supplements, except as specifically stated under the “Special Food Products” provision of MEDICAL CARE THAT IS COVERED.

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

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. This exclusion will not apply to services and supplies for routine patient care costs in connection with phase I, phase II, phase III and phase IV cancer clinical trials, as specifically stated under the "Cancer Clinical Trials" provision of MEDICAL CARE THAT IS COVERED,

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

Government Treatment. Any services you actually received that were provided by a local, state or federal government agency, except when payment under this *benefit program* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

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

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis of infertility, except as specifically stated in "Family Planning" provision of MEDICAL CARE THAT IS COVERED. Treatment of *infertility,* including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

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

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

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions.

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

Not Covered. Services received before your *effective date* or after your coverage ends.

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

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

Optometric Services or Supplies. Eye exams except as specifically stated under "Well Baby and Well Child Care" and "Preventive Care" provisions of MEDICAL CARE THAT IS COVERED. Other optometric services, eye exercises including orthoptics and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Orthodontia. Braces and other orthodontic appliances or services.

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

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

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

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

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

Prescription Drugs and Medications. Any drug or medicine, except as specifically stated in the "Prescription Drugs and Medications" provision of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

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

Private Duty Nursing. Services of a private duty nurse, except as specifically stated in the “Outpatient Private Duty Nursing” provision of MEDICAL CARE THAT IS COVERED.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the “Well Baby and Well Child Care,” "Preventive Care", "Cervical Cancer Screening", "Breast Cancer" or “Prostate Cancer Screening” provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

Sterilization Reversal. Reversal of sterilization.

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

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

1. It must be internationally known as being devoted mainly to medical research;

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

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

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

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Information can be found in your LANS SPD.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

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 *benefit program* which provides benefits subject to this provision.

EFFECT ON BENEFITS

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

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision provides benefits before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current

employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as a *subscriber*.

For example: You are covered as a retired *subscriber* under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first and the plan which covers you as a retired *subscriber* will pay last, after Medicare.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* provides benefits before the plan of the parent whose birthday falls later in the *calendar year*. However, 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 provides benefits 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 provided 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 provides benefits first.

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

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

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest provides benefits 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. The Benefit Program is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

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

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, 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 the benefits provided under This Plan exceed the maximum amount necessary to satisfy the intent of this provision, the *medical group* and we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Family Members. Any *member* who is an *employee* or a *family member* of an active *employee*, and eligible for Medicare, will receive the full benefits of this *benefit program*, except for the following:

1. *Members* who are receiving treatment for end-stage renal disease following the first 30 months such *members* are entitled to end-stage renal disease benefits under Medicare; and

2. *Members* who are entitled to Medicare benefits as disabled persons; unless the *members* have a current employment status, as determined by Medicare rules, through a *group* of 100 or more employees (according to OBRA legislation).

For cases where exceptions 1 or 2 apply, the *claims administrator* will determine our payment and then subtract the amount of benefits available from Medicare. We will pay the amount that remains after subtracting Medicare's payment. Please note we will not pay any benefit when Medicare's payment is equal to or more than the amount which we would have paid in the absence of Medicare.

For Retired Employees and Their Spouses. If you are a retired employee or the *spouse* of a retired employee and you are enrolled for Medicare Part A and/or Part B, your benefits under this *benefit program* will be reduced.

When you incur *covered expense* under this *benefit program*, the *claims administrator* will determine this *benefit program's* payment and then subtract the amount of your benefits available from Medicare Parts A and B. This *benefit program* will pay the amount that remains after subtracting Medicare's benefits.

For example: Say you are a retired employee, a retired employee's *spouse* or that exceptions 1 or 2 above for active employees and *family members* apply to you. Say also that you are billed for **$100** of *covered expense*, by a Medicare provider who accepts assignment:

Medicare allowable expense	$62.50
Medicare payment	$50.00
Our payment	$12.50
Member payment	None

The combined amount of benefits from Medicare and this *benefit program* will equal, but not exceed, what your benefit would have been from this *benefit program* alone if you were not eligible for Medicare.

Electronic Claims Coordination

If you are covered by Medicare, call the *claims administrator's* Customer Service unit at 1 (800) 759-3030 and give them your Medicare number. The *claims administrator* will load it to its membership system, which will permit the *claims administrator* to electronically receive your Medicare EOB. This will allow the *claims administrator* to generate your LANS benefit from this Benefit Program without you having to submit a claim.

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization, and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to *hospital* admissions. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

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

Important: Medical management requirements described in this section do not apply when coverage under this *benefit program* is secondary to another plan providing benefits for you or your *family members*.

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to inpatient *hospital* admissions. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

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

Important: Medical management requirements described in this section do not apply when coverage under this *benefit program* is secondary to another plan providing benefits for you or your *family members*.

UTILIZATION REVIEW PROGRAM

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for all inpatient *hospital stays.*

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

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

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency inpatient *hospital* services.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or the *claims administrator* is notified while service is ongoing, for example, an emergency admission to the hospital.

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *benefit program*. When pre-service review is not performed as required for an inpatient *hospital* admission, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *benefit program* requires pre-service review. The toll-free number for pre-authorization and pre-service review is printed on your identification card.

3. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure. The toll-free number is printed on your identification card.

2. When the *claims administrator* determines that the service is *medically necessary* and appropriate, it will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.

3. If the *claims administrator* determines that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the decision. The *claims administrator* will send written notice to you and your *physician* within two business days following its decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrator* is not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

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

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

AUTHORIZATION PROGRAM

The authorization program provides prior authorization for certain "special services".

It is your responsibility to obtain authorization before you receive any service subject to the authorization program. The toll-free number to call for authorization is shown on your *benefit program* identification card. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of AUTHORIZATION PROGRAM.

SERVICES REQUIRING AUTHORIZATION

1. Organ and tissue transplants.

2. Transplant travel expense benefits.

EFFECT ON BENEFITS

When the appropriate authorization is not obtained, the benefits to which you would have been otherwise entitled **will be reduced by $500 for each occurrence. In addition, services for organ and tissue transplants are not covered when performed at other than an approved transplant center.**

WHEN AUTHORIZATION WILL BE PROVIDED

1. **Organ and Tissue Transplants.** Authorizations for organ and tissue transplants will be provided only if both of the following criteria are met:

   a. The services are *medically necessary;* and

b. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

2. **Transplant Travel Expense Benefits.** Authorizations for transplant travel expense benefits will be provided for the recipient or donor only if all of the following criteria are met:

   a. It is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, authorized by us;

   b. The organ transplant must be performed at an approved transplant center*;* and

   c. The transplant center is 250 miles or more from the recipient or donor's home.

HOW TO OBTAIN AN AUTHORIZATION

You or your *physician* must call the toll-free telephone number printed on your identification card before the services are rendered.

THE MEDICAL NECESSITY REVIEW PROCESS

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

1. A decision on the medical necessity of a pre-service request will be made no later than 2 business days from receipt of the information necessary to make the decision.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information necessary to make the decision.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision.
4. If the *claims administrator* does not have the needed information, the *claims administrator* will make every attempt to obtain that information from you or your *physician*. If unsuccessful, and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what the *claims administrator* needs to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service certified as *medically necessary* will be sent to you and your provider no later than 2 business days from the decision.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted telephonically for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

    - an explanation of the reason for the decision,
    - reference of the criteria used in the decision to modify or not certify the request,
    - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
    - how to request reconsideration if you or your provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party chosen at the *claims administrator's* sole and absolute discretion.

10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your *benefit program* identification card. The claims administrator discloses its medical necessity review procedures to health care providers through provider manuals and newsletters.

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

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

PERSONAL CASE MANAGEMENT

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

HOW PERSONAL CASE MANAGEMENT WORKS

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

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

1. You require extensive long-term treatment;
2. The *claims administrator* anticipates that such treatment utilizing services or supplies covered under this *benefit program* will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this *benefit program* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *benefit program* while maintaining the same standards of care*;* and

4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

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

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

EFFECT ON BENEFITS

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

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

QUALITY ASSURANCE

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

ERISA CLAIMS AND APPEALS PROCEDURES

The plan document and this booklet entitled "Benefit Program Summary," contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator.) The rules required by ERISA are set forth below.

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

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

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15-days after they receive your request for benefits that they have received your request and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they have received your request and tell you what information is missing. You have 45-days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

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

Concurrent Care Decisions:

- **Reduction of Benefits –** If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in

benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal the Claims Administrator's decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.

- If the Claims Administrator receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).

- **Extension of Benefits –** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

  - You must make a request to the Claims Administrator for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

  - If the Claims Administrator receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of your request if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30-days after they receive your claim for benefits, that they have received your request and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they have received your request and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the

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

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

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

You may have representation throughout the appeal and review procedure.

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

Please refer to your LANS SPD for additional information regarding ERISA Claims and Appeals Procedures, and other important information.

HIPAA COVERAGE AND CONVERSION

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

HIPAA Coverage

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

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of the required monthly contribution, premiums or fraud.
3. If continuation of coverage under the employer plan was available under COBRA, CalCOBRA, or a similar state program including Senior COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medicaid, or any group medical coverage and cannot have other medical coverage.

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

Conversion Coverage

To apply for a conversion plan, you must submit an application to the *claims administrator* and make the first premium payment within 63 days of the date your coverage under the employer's *benefit program* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

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

The three consecutive month period of coverage requirement will be waived for *members* who have been covered under another LANS plan then switch to this *benefit program* during an Open Enrollment and need to convert prior to being covered for three consecutive months under this *benefit program*.

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

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

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

CERTIFICATION OF CREDITABLE COVERAGE

The *claims administrator* will provide certifications of periods of creditable coverage for *members* whose coverage under the *benefit program* terminates.

GENERAL PROVISIONS

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

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not their agents nor are they, or any of their employees, an employee or agent of any *hospital,* medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *benefit program* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Blue Cross and/or Blue Shield Providers. When you obtain covered health care services, the amount you pay, if it is not a flat dollar amount, is usually calculated on the lower of the:

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

Often, this "negotiated price," referred to above, will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

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

Terms of Coverage

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

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

Continuity of Care. If a Blue Cross or Blue Shield Plan terminates its contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the

contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the *claims administrator* at the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *benefit program* applicable to *participating providers*.

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

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

Benefits Not Transferable. Only *members* are entitled to receive benefits under this *benefit program*. The right to benefits cannot be transferred.

Notice of Claim. You, or someone on your behalf, must give the *claims administrator* written notice of a claim within 20 days after you incur *covered expense* under this *benefit program*, or as soon as reasonably possible thereafter.

Claim Forms. After the *claims administrator* receives a written notice of claim, the *claims administrator* will give you any forms you need to file proof of loss. If you are not given these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending the *claims administrator* written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

Proof of Loss. You or the provider of service must send the claims administrator properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *benefit program* if you do not file claims within the required time period. We will not be liable for benefits if the *claims administrator* does not receive written proof of loss on time.

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

Timely Payment of Claims. Any benefits due under this *benefit program* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

Payment to Providers. The *claims administrator* will pay the benefits of this *benefit program* directly to medical transportation providers. Also, other providers of service will be paid directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, the *claims administrator* will pay the benefits of this *benefit program* to that party. These payments will fulfill our obligation to you for those covered services.

Exception: Under certain circumstances the *claims administrator* will pay the benefits of this *benefit program* directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide the *claims administrator* the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;

2. If the *subscriber* does not reside with the patient, either a copy of the judicial order requiring the *subscriber* to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with the *claims administrator* on an annual basis;

3. If the *subscriber* does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the *subscriber* to provide coverage for the patient or a state approved form verifying the existence of such judicial order;

4. The name and address of the person to be reimbursed, the name and policy number of the *subscriber*, the name of the patient, and other necessary information related to the coverage.

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

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

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

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

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *benefit program* or breach thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, may 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 may be resolved in such court.

The arbitration is begun by the *member* making written demand on the *plan administrator* after an appeal on a claim for benefits has been denied. 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 *plan administrator*, or by order of the court, if the *member* and *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the *member* and *plan administrator*.

The *plan administrator* and the *member* may agree to be bound by the arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

If so agreed upon by the *plan administrator* and 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.

DEFINITIONS

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

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

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

Benefit Program refers to the "Core NM Plan without Medicare."

Child meets the eligibility requirements for children outlined in the LANS SPD.

Claims administrator refers to BC Life & Health Insurance Company. On behalf of BC Life & Health Insurance Company, Blue Cross of California shall perform all administrative services in connection with the processing of claims under the *benefit program.*

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

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under a publicly sponsored program such as Medicare or Medicaid, CHAMPUS, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, or coverage through the Peace Corps. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

You are considered to have been covered under a creditable coverage if you: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *benefit program* within 63 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

You are also considered to have been covered under a creditable coverage if your employment ended, the availability of medical coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward medical coverage terminated, provided that you: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *benefit program* within 180 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

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

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

Drug (prescription drug) means a prescribed drug approved by the Food and Drug Administration for general use by the public. For the purposes of this *benefit program,* insulin will be considered a prescription drug.

Effective date is the date your coverage begins under this *benefit program*.

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

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

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

Family Member meets the eligibility requirements for family members outlined in the LANS SPD.

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

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

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

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

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

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

LANS refers to LOS ALAMOS NATIONAL SECURITY, LLC.

LANS SPD refers to LANS Welfare Benefit Plan for Employees Summary Plan Description or the LANS Welfare Benefits Plan for Retirees Summary Plan Description, as applicable.

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

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

Medicare is the name commonly used to describe "Health Insurance Benefits for the Aged and Disabled" provided under Public Law 89-97 and its amendments.

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

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

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

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

Non-participating provider is a *hospital* or *physician* NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *benefit program*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;

2. A facility which provides diagnostic radiology services;
3. A blood bank;
4. A durable medical equipment outlet;
5. A clinical laboratory;
6. A *skilled nursing facility;*
7. A *home health agency;*
8. A licensed ambulance company;
9. A *hospice;*
10. An *ambulatory surgical center;*
11. A *home infusion therapy provider;* or
12. A licensed birth center; or
13. A *pharmacy.*

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

Participating provider is a *hospital* or *physician* participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. *Participating providers* agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Pharmacy means a licensed retail pharmacy.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:

    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist
    f. A chiropractor (D.C.)
    g. An acupuncturist (A.C.)
    h. A clinical social worker (L.C.S.W.)
    i. A marriage and family therapist (M.F.T.)
    j. A physical therapist (P.T. or R.P.T.)*
    k. A speech pathologist*
    l. An audiologist*
    m. An occupational therapist (O.T.R.)*
    n. A respiratory care practitioner (R.C.P.)*
    o. A *psychiatric mental health nurse* (R.N.)*
    p. A nurse midwife
    q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

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

Plan refers to the LANS Welfare Benefit Plan for Employees or the LANS Welfare Benefit Plan for Retirees, as applicable.

Plan administrator refers to LOS ALAMOS NATIONAL SECURITY, LLC, the entity responsible for the administration of the *benefit program.*

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

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

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

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

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

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

Spouse meets the eligibility requirements for spouses outlined in the LANS SPD.

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

Subscriber is the person who, by meeting the eligibility requirements, is allowed to choose coverage under this *benefit program* for himself or herself and his or her eligible *family members*. Such requirements are outlined in the LANS SPD.

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

We (us, our) refers to the Benefit Program.

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

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

COMPLAINT NOTICE

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

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

Claims Administered by:

BLUE CROSS OF CALIFORNIA

on behalf of

BC LIFE & HEALTH INSURANCE COMPANY