FOREWORD

The plan described on the following pages provides benefits for a wide range of services and supplies for medical care.

Your medical benefit plan is a self-funded program provided by the University of Southern California (the “University”). Benefits are administered by the University with HealthComp, Anthem Blue Cross, and MedImpact, each providing certain administrative services.

The USC Group Health Plan provides self-insured medical benefits under the USC PPO Plan. This booklet constitutes the portion of the plan document that describes the USC PPO Plan.

The University of Southern California reserves the right to amend or terminate the USC PPO Plan at any time, or terminate any benefit under the Plan.

Plan Administrator’s Decision Final. The administration of the Plan shall be under the supervision of the Plan Administrator, which is the University and the University’s delegate, USC Health Plans (hereafter, collectively, the “Plan Administrator”). To the fullest extent permitted by law, the Plan Administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, and the Plan Administrator shall have the discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination by the Plan Administrator shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

### IMPORTANT CONTACTS

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<th><strong>Anthem Blue Cross</strong></th>
<th>(800) 274-7767</th>
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<td><strong>Plan Coverage Questions</strong></td>
<td><strong>HealthComp</strong></td>
<td>(855) SC-PLANS (855) 727-5267 <a href="http://www.healthcomp.com">www.healthcomp.com</a></td>
</tr>
<tr>
<td><strong>Claim Questions</strong></td>
<td><strong>HealthComp</strong></td>
<td>(855) SC-PLANS (855) 727-5267 <a href="http://www.healthcomp.com">www.healthcomp.com</a></td>
</tr>
<tr>
<td><strong>Find a Participating Network Provider</strong></td>
<td><strong>Tier 1 Providers:</strong> Keck Medicine of USC (833) KECK-USC (833-532-5872) <a href="http://www.keckmedicine.org">www.keckmedicine.org</a></td>
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</tr>
<tr>
<td></td>
<td><strong>Tier 2 Providers:</strong> Anthem Blue Cross Prudent Buyer and BlueCard® BlueCard Worldwide®</td>
<td>(800) 888-8288 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> (800) 810-2583 <a href="http://www.bluecardworldwide.com">www.bluecardworldwide.com</a></td>
</tr>
<tr>
<td></td>
<td><strong>Contracted Pharmacies:</strong> MedImpact</td>
<td>(844) 401-2054 mp.medimpact.com</td>
</tr>
<tr>
<td><strong>For help scheduling an appointment with a Keck Medicine provider</strong></td>
<td><strong>Keck Medicine of USC</strong></td>
<td>(833) KECK-USC (833-532-5872)</td>
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<td>(844) 401-2054 mp.medimpact.com</td>
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<td>(833) KECK-USC (833-532-5872)</td>
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**You can also visit the USC PPO Plan’s website for other important information and links:**

https://benefits.usc.edu/healthcare/medical/useppo
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IMPORTANT NOTE ABOUT YOUR MEDICAL PLAN

YOUR MEDICAL PLAN CONTAINS A PRIOR AUTHORIZATION PROGRAM, AS DESCRIBED ON PAGES 17-18.

Failure to follow the Prior Authorization Program may result in a reduction or denial of benefits, which may mean a greater expense to you.

TO ARRANGE FOR A PRIOR AUTHORIZATION, PLEASE CONTACT ANTHEM BLUE CROSS AT (800) 274-7767.

USC's Preferred Provider Organization Program

USC Network Providers are comprised of two tiers of Participating Providers, Tier 1 and Tier 2. Tier 1 consists of Keck Medicine of USC Physicians, Keck Hospital of USC, USC Norris Cancer Hospital, and USC Verdugo Hills Hospital. Tier 2 consists of all Anthem Blue Cross Prudent Buyer providers in California, participating BlueCard® providers in other parts of the United States (with the exception of vision and dental providers) and participating BlueCard Worldwide® providers outside of the United States. You may also obtain Medically Necessary Covered Services from Non-Network (Tier 3) providers; however, the rate of Plan payment under your medical expense benefit is much greater for services furnished by USC Network Providers.

If your Network Physician refers you to another Physician or provider, it is your responsibility to verify that the Physician/provider is also a Participating Network Provider. If the Physician/provider is not a Participating Network Provider, Benefits will be paid at the out-of-Network rate and you will be responsible for the remainder of the charges.

If you seek treatment at an Network facility (e.g., hospital or outpatient surgery center) and a Non-Network provider (e.g., a Non-Network Physician, anesthesiologist, radiologist, respiratory therapist) participates in your treatment, the Non-Network provider’s claim will be paid at 80% of Usual, Customary and Reasonable (UCR) Charges, the Tier 2 deductible will apply and the Tier 3 annual out-of-pocket maximum will apply in accordance with applicable law, except where noted under Covered Services section for specific services. You will always be responsible for all billed charges which exceed the Usual, Customary and Reasonable (UCR) charges, in addition to your responsibility for any applicable copayments and coinsurance amounts.

USC is not responsible for the quality and extent of care you may receive at any of the Network Hospitals or from any specific Network Provider. The Plan does not assure that all services will be available from Tier 1 providers and will not extend Tier 1 coverage to Tier 2 or 3 providers. It is important that you request information on proposed medical treatment directly from the Hospital and your Physician.

Rate of Payment Adjustment

You generally pay lower Coinsurance and Copayments when Medically Necessary Covered Services are provided by Tier 1 and Tier 2 providers. If you obtain Medically Necessary Covered Services from Non-Network providers (Tier 3), the Plan will pay up to 50% of Usual Customary and Reasonable (UCR) charges for Physician and ancillary services and you will be responsible for the remainder of the charges. For inpatient Medically Necessary Covered Services provided by a Non-Network Hospital, you will pay a $600 Copayment per admission plus at least 50% of the charges made by the Hospital, subject to the applicable out-of-pocket maximum. For Medically Necessary outpatient surgeries provided by a Non-Network Hospital or Non-Network outpatient facility, the Plan will pay up to 50% of Usual Customary and Reasonable (UCR) charges, not to exceed a Plan payment of $2,700. You will pay a $600 Copayment, plus the remainder of all charges made by the Non-Network Hospital or Non-Network outpatient facility.
PROVISIONS APPLYING TO THE PLAN — Continued

Special Benefit for Covered Persons Under Age 19
The PPO Plan pays the Tier 1 Benefits to Tier 2 providers, when services are rendered to Covered Persons under age 19.

The Deductible
The Plan has a Calendar Year deductible that will apply to Eligible Expenses which do not have a flat dollar copay. You must meet your annual deductible before the Plan will pay Benefits. The Calendar Year deductible does apply (count toward) your annual medical out-of-pocket limit.

Individual
The individual Calendar Year deductible is the first $100 of Eligible Expenses for services provided by Tier 1 providers, $250 with Tier 2 and $600 with Tier 3 providers.

Family
Each individual deductible incurred (met) is applied to the family deductible. The family deductible does not have to be met before Plan Benefits are paid for a single Covered Person in a family. The family Calendar Year deductible is met collectively when three or more Covered Persons in a family have Eligible Expenses where the deductible applies (not counting more than the individual deductible for any one person). Once your family deductible is met, the Plan will pay Benefits for all members in the family, regardless of whether each member has met their individual deductible.

Deductible Cross Accumulates for Tier 1 and Tier 2
When a combination of Tier 1 and Tier 2 providers are used, the deductible will accumulate across Tiers 1 and 2. The deductible for Tier 3 is stand-alone and does not cross accumulate with Tiers 1 and 2.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
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<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 Providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td><strong>Annual Deductible</strong></td>
<td><strong>Annual Deductible</strong></td>
</tr>
<tr>
<td>Individual</td>
<td>$100</td>
<td>$250</td>
</tr>
<tr>
<td>Family (3 or more persons)</td>
<td>$300</td>
<td>$750</td>
</tr>
</tbody>
</table>

Note: The individual deductible for Covered Persons less than 19 years of age is $100 for Covered Services rendered by both Tier 1 and Tier 2 providers. Therefore, if a family is comprised of one adult and two children under age 19, all of whom seek services only from Tier 2 providers, the annual family deductible will be $450 ($250 for the adult + $100 for each child = $450).

Carryover of Expenses Year–to–Year
There is no carryover of expense from one year to another. Limits on Benefits start anew each January 1.
PROVISIONS APPLYING TO THE PLAN — Continued

Out–Of–Pocket Limits
The USC PPO Plan limits your expenses each year. Once a Covered Person has met the out-of-pocket maximum(s) set forth below in one Calendar Year, the percentage covered by the PPO Plan increases for that year.

If you receive all of your care through Tier 1 providers, your annual medical out-of-pocket maximum will be $1,500 per person or a maximum of three individuals within a family ($1,500 x 3 people). If you receive your care from Tier 2 providers (Anthem Blue Cross Prudent Buyer providers and/or participating BlueCard® program providers), your annual medical out-of-pocket maximum will be $2,500 per person or a maximum of three individuals within a family ($2,500 x 3 people). If you receive your care from Non-Network providers (Tier 3) your annual medical out of pocket maximum will be $12,500 per person or $37,500 within a family ($12,500 x 3 people) and then the rate of payment for Eligible Expenses will be increased to 100% of UCR. Once you have reached the Tier 3 medical out of pocket maximum, you will still be responsible for any amount over 100% of UCR. In other words, you remain responsible for all charges in excess of UCR even after you reach those out-of-pocket maximums.

Medical out-of-pocket limits are cumulative per person and transferable between Tiers 1 and 2. For example, if you accumulate $500 towards your Tier 1 medical out-of-pocket limit, that $500 will also be considered as applying towards your Tier 2 medical out-of-pocket limit. If you accumulate $2,000 towards your Tier 2 medical out-of-pocket limit, your Tier 1 medical out-of-pocket limit will be satisfied and the $2,000 would also apply to your Tier 2 limit.

The out-of-pocket prescription Copay/Coinsurance maximums for the Plan are $4,850 maximum for an individual and $7,200 maximum for a Family (2 or more persons). This is a separate out-of-pocket maximum from the Plan’s medical out-of-pocket maximum in a Calendar Year. This means that after a single person meets the prescription out-of-pocket maximum of $4,850 in a Calendar Year, he/she will be covered at 100% for covered prescriptions filled at Network pharmacies for the remainder of the Calendar Year. For an employee covering one or more dependents, when the covered persons cumulatively reach the $7,200 prescription out-of-pocket maximum, all covered members of the Family will be covered at 100% for covered prescriptions filled at Network pharmacies for the remainder of the Calendar Year.

This does not imply coverage in excess of limits expressed elsewhere.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
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<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 Providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td><strong>Medical Out-of-Pocket Limits (Per Calendar Year)</strong></td>
<td><strong>Medical Out-of-Pocket Limits (Per Calendar Year)</strong></td>
<td><strong>Medical Out-of-Pocket Limits (Per Calendar Year)</strong></td>
</tr>
<tr>
<td>$1,500/person (maximum of 3 individuals within a family) Thereafter, coverage increases to 100%</td>
<td>$2,500/person (maximum of 3 individuals within a family) Thereafter, coverage increases to 100%</td>
<td>$12,500/person (maximum of 3 individuals within a family) Thereafter, coverage increases to 100% of UCR. You are responsible for any amount above 100% of UCR</td>
</tr>
<tr>
<td><strong>Prescription Out-of-Pocket Limits (Per Calendar Year)</strong></td>
<td><strong>Network Pharmacies</strong></td>
<td><strong>Non-Network Pharmacies</strong></td>
</tr>
<tr>
<td>$4,850 maximum for an individual</td>
<td></td>
<td>No Out-of-Pocket maximum</td>
</tr>
<tr>
<td>$7,200 maximum for two or more individuals within a family</td>
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DEFINITIONS FOR THE PURPOSE OF THE PLAN

BENEFICIARY/COVERED PERSON
means a person who is entitled to Covered Services and who, on the date health care services are rendered, has satisfied the eligibility requirements of the Plan and who has elected to be covered by the Plan.

BENEFITS
means the dollar amount payable for a Covered Service after the application of deductible/Coinsurance/Copayments under the Plan, subject to all of the terms and conditions of the Plan.

BRAND NAME DRUG
means a single-source and/or multisource non-generic prescription drug as determined by using First Data Bank indicators in accordance with the drug classification requirements of USC’s Prescription Drug Program Agreement with MedImpact.

BUSINESS DAY
means a weekday that is not a recognized holiday between the hours of 8:30 a.m. to 5:00 p.m.

CALENDAR YEAR
means the period of time from any January 1st through the following December 31st. When a person first enrolls in the PPO Plan, his/her first Calendar Year begins on the Effective Date of his/her enrollment and ends on the coinciding or following December 31st.

COINSURANCE
means the portion of the Eligible Expense for which the Covered Person has a financial responsibility, usually according to a fixed percentage. The percentage of covered expenses that you pay is your coinsurance. Coinsurance applicable to coverage in Tiers 1 and 2 is calculated as a percentage of the contract rate in effect with the provider at the time the service was rendered or the supply was furnished. Coinsurance applicable to coverage in Tier 3 is calculated as a percentage of the Usual, Customary and Reasonable (UCR) fees charged by similar providers for the same services in similar circumstances and in the same or similar geographic area, as determined by the Plan Administrator in its sole discretion, at the time the service was rendered or the supply was furnished.

COPAYMENT
means the fixed dollar amount which must be paid directly by the Covered Person to the provider. (See page 56, “Patient Responsibility For Payment”.)

COSMETIC SURGERY
means surgery performed mainly to change a person's appearance (including, but not limited to, “cosmetic surgery” as defined under Section 213(d)(9)(B) of the Internal Revenue Code). It includes surgery performed to treat mental, psychoneurotic and personality disorders through change in appearance.

COVERED SERVICES
means all Medically Necessary Physician services and health care services and supplies that are provided by or at the direction of a Physician, and for which Benefits are expressly available under the Plan, subject to the exclusions and limitations set forth herein.

CUSTODIAL CARE
means services which are intended to help a Covered Person meet the activities of daily living, whether he/she is disabled or not. “Activities of daily living” include but are not limited to:
DEFINITIONS FOR THE PURPOSE OF THE PLAN — Continued

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<td>Managing money</td>
<td>Pushing/Pulling</td>
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<td>Dressing</td>
<td>Using public transportation</td>
<td>Laundry</td>
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<td>Using a telephone</td>
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</table>

DOCTOR/PHYSICIAN
means a person licensed under the laws of the state in which he/she practices medicine within the scope of his/her license.

DURABLE MEDICAL EQUIPMENT
means that equipment is (1) able to withstand repeated use, (2) primarily and customarily used to serve a medical purpose, and (3) not generally useful to a person in the absence of illness or injury. Examples include: wheelchair, walker, bed, bedside commode, crutches, apnea monitor, blood glucose machine and nebulizer.

ELIGIBLE EXPENSES/CHARGES
means those charges or expenses for Covered Services, subject to the terms and limitations of the Plan. For example, reimbursement for Eligible Expenses of Non-Network Providers is limited to the applicable reimbursement percentage of Usual, Customary and Reasonable Charges (UCR), while for Network Providers, reimbursement of Eligible Expense is limited to the applicable reimbursement percentage of the reimbursement provided under the terms of the Network Provider’s applicable contractual arrangement.

EMERGENCY
means a situation requiring Emergency Services.

EMERGENCY SERVICES
means the treatment given in a Hospital’s emergency room to evaluate and treat medical conditions of recent onset and severity - including (but not limited to) severe pain - that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the person’s health in serious jeopardy, or
2. serious impairment to bodily function, or
3. serious dysfunction of a body part or organ, or
4. serious jeopardy to the health of the fetus (in the case of a pregnant woman).

EXPERIMENTAL OR INVESTIGATIONAL
means any treatment, service or supply that is:

1. not universally accepted by informed health care professionals in the United States as safe, appropriate, and more effective than medically accepted alternatives, or
2. not likely to restore health and extend life as determined by the Plan Administrator in its discretion, or
3. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, or
4. subject to federal laws requiring Institutional Review Board review and approval for the proposed use, or
5. the subject of ongoing FDA regulated Phase I, II, or III clinical trial, except where federal law requires coverage under the USC PPO Plan for any treatment, service or supply in connection with an approved clinical trial, or
DEFINITIONS FOR THE PURPOSE OF THE PLAN — Continued

6. not conclusively demonstrated to Plan Administrator’s satisfaction to be safe, cost effective, likely to restore health and extend life and more effective than medically accepted alternatives.

However, the following are not considered experimental or investigational:

Transplantation
Any human solid organ or bone marrow/stem cell transplant provided that:

a. the condition is life-threatening; and
b. such transplant for that condition is the subject of an ongoing Phase III clinical trial or is otherwise not experimental or investigational as provided above with respect to legally-required coverage for services and supplies in connection with an approved clinical trial; and

c. such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and

d. the Covered Person is a suitable candidate for the transplant under the medical protocols used by Anthem Blue Cross and approved from time to time by the Plan Administrator; and

e. the transplant is more effective than medically-accepted alternatives and likely to restore health and extend life, as determined by the Plan Administrator, in its discretion.

Drugs
Any drug or biologic which has been approved by the Food and Drug Administration (FDA), provided that it:

1. conforms to FDA approved use guidelines; or
2. conforms to usage listed in a Recognized National Compendia.

Medical Devices
Any medical device provided that it:

1. has been approved by the FDA; and
2. conforms to FDA approved use guidelines.

FAMILY UNIT
means an employee and his/her covered dependents.

GENERALLY ACCEPTED BY THE MEDICAL COMMUNITY IN THE UNITED STATES
means that the clinical efficacy of the treatment has been documented in credible, published medical literature which demonstrates that the results of the treatment have been measured for a 5 year period or other period generally regarded as valid.

GENERIC DRUG
means a single and/or multi-source non-brand prescription drug, whether identified by its chemical, proprietary or nonproprietary name, as determined by using First Data Bank indicators in accordance with the drug classification requirements of USC’s Prescription Drug Program Agreement with MedImpact.

HOME HEALTH CARE AGENCY
means any of the following: (1) a home health agency licensed by the state of operation, or (2) a home health agency as defined under Medicare, or (3) an organization which is certified by the patient's Physician as an appropriate provider of home health services, has a full-time administrator, keeps medical records and has at least one Registered Nurse (R.N.) or one’s services available.
DEFINITIONS FOR THE PURPOSE OF THE PLAN — Continued

HOME HEALTH CARE PLAN
means a written program for care and treatment in the patient's home and certification that continued inpatient confinement in a Hospital or nursing facility would be required if the home care were not provided.

HOSPICE SERVICES
means those services provided by a licensed or certified provider of care to a terminally ill person to (1) reduce or abate pain or other symptoms of mental or physical distress, and (2) meet the special needs arising out of the stresses of the terminal illness, dying and bereavement.

HOSPICE TEAM
means a team of professionals and volunteer workers which includes at least: a Physician; a registered nurse; and could include the following: a social worker, a clergyman/counselor; volunteers; a clinical psychologist; physiotherapist; and occupational therapist.

HOSPITAL
means an institution licensed as a hospital by the appropriate state and local authorities and approved by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

IMMUNIZATION
means a procedure to render an individual resistant to infection or disease.

INPATIENT CONFINEMENT
means that a Covered Person is duly admitted by a Physician and is registered as a bed patient in a Hospital or Skilled Nursing Facility (SNF).

MEDICALLY NECESSARY
means services are Covered Services that are necessary and appropriate for treatment of a Covered Person’s illness or injury according to generally accepted standards of medical practice.

A service or supply is Medically Necessary only when it meets all of the following requirements:

1. it must be legal, ordered by a physician, safe, cost effective and appropriate in treating the condition for which it is ordered;
2. it must not be considered experimental or investigational;
3. it must be the proper quantity, frequency and duration for treatment of the condition for which it is ordered;
4. it must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered;
5. it must not be custodial;
6. its purpose must be to restore health and extend life and must, in the judgment of the Plan Administrator, be likely to accomplish that purpose; and
7. for any type of bariatric surgery or procedure, in addition to meeting all of the above requirements, such surgery or procedure must satisfy Anthem Blue Cross’ Medical Policy requirements and must also have prior authorization from Anthem Blue Cross. For more information about those Medical Policy requirements, you may contact Anthem Blue Cross directly.

As indicated above, to be Medically Necessary, a procedure must, in the judgment of the Plan Administrator, be likely to accomplish its intended purpose of restoring health and extending life.

MENTAL DISORDER
means a disease commonly understood to be a mental disorder under generally recognized independent standards of current medical practice and applicable law, whether or not it has a physiological or organic basis. Treatment for
DEFINITIONS FOR THE PURPOSE OF THE PLAN — Continued

mental disorders is usually provided by, or under the direction of, a mental health or chemical dependency provider such as a psychiatrist, psychologist, or psychiatric social worker. Mental disorders include (but are not limited to):

- Chemical dependency
- Schizophrenia
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

NETWORK SERVICE AREA
Generally means the United States of America (except for any Tier 2 Providers located outside the United States of America).

NETWORK PROVIDER/PARTICIPATING NETWORK PROVIDER
means Tier 1 or Tier 2 health care providers listed on the Keck Medicine of USC website available at www.keckmedicine.org, Keck Hospital of USC, USC Norris Cancer Hospital, USC Verdugo Hills Hospital, Anthem Blue Cross Prudent Buyer and BlueCard® providers at www.anthem.com/ca for providers within the United States and BlueCard Worldwide® program providers outside of the United States at www.bluecardworldwide.com.

NON-NETWORK PROVIDER
means any Physician, Hospital or ancillary provider who does not have a contract with the USC PPO Plan, Anthem Blue Cross Prudent Buyer or the BlueCard® program (Tier 2).

PLAN
means the USC PPO Plan.

PREVENTIVE CARE
means health screening and immunizations at designated intervals depending upon age, including any recommended preventive services that the Plan is required to cover under the Patient Protection and Affordable Care Act (“PPACA” or the “Affordable Care Act”).

RECOGNIZED NATIONAL COMPENDIA
means the American Hospital Formulary Service, the American Medical Association Drug Evaluations or the U.S. Pharmacopoeia Drug Information of the Health Care Professional.

REMISSION
means a halt in the progression of a terminal disease or an actual reduction in the extent to which the disease has already progressed.

RESIDENTIAL TREATMENT CENTER
means an institution that meets all of the following requirements:
- Has an on-site, licensed medical or chemical dependency providers 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Patients are admitted by a physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week. The treatment must be actively supervised by an attending physician.
• Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
• Offers group therapy sessions with at least an RN or Masters-level health professional.
• Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
• Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
• Has peer oriented activities.
• Its services are managed by a licensed chemical dependency health provider who, while not needing to be individually contracted, needs to:
  ➢ Meet the Claim Administrator’s credentialing criteria as an individual practitioner, and
  ➢ Function under the direction/supervision of a licensed psychiatrist (Medical Director).
• Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
• Provides a level of skilled intervention consistent with patient risk.
• Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
• Is not a wilderness treatment program or any such related or similar program, school and/or education service.
• Is able to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
• Provides 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.

SKILLED NURSING FACILITY
means a licensed institution that (1) provides 24–hour care by one or more professional nurses, (2) is under full-time supervision of a Physician, (3) keeps medical records as required by the licensing body, and (4) is not an institution, or part of one, used mainly as a rest facility or a facility for the aged.

SMOKING CESSATION PROGRAM
means a structured outpatient program of not greater than 12 weeks, designed to provide behavior modification tools to assist a Covered Person in ceasing tobacco use.

SURGERY CENTER
means a freestanding ambulatory surgical facility that:
• Meets licensing standards.
• Is set up, equipped and run to provide general surgery.
• Makes charges for its services.
• Is directed by a staff of physicians, at least one of whom is on the premises when surgery is performed and during the recovery period.
• Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period.
• Extends surgical staff privileges to physicians who practice surgery in an area hospital and to dentists who perform oral surgery.
• Has at least two operating rooms and one recovery room.
• Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery.
• Does not have a place for patients to stay overnight.
• Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN.
• Is equipped and has staff trained to handle medical emergencies.
• Must have a physician trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander.
DEFINITIONS FOR THE PURPOSE OF THE PLAN — Continued

- Has a written agreement with an area hospital for the immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program that includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record for each patient.

SURGICAL PROCEDURES
means only: cutting, suturing, correction of a fracture, reduction of a dislocation, electrocauterization, tapping (paracentesis, arthrocentesis), amniocentesis, administration of artificial pneumothorax, laparoscopic and arthroscopic procedures, or injection of sclerosing solution.

TERMINALLY ILL PERSON
means a Covered Person whose life expectancy is six months or less, as certified by the primary attending Physician.

TIER 1
means Keck Medicine of USC Physicians, Keck Hospital of USC, USC Norris Cancer Hospital, and USC Verdugo Hills Hospital.

TIER 2
means any Anthem Blue Cross Prudent Buyer and BlueCard® program provider with the exception of vision and dental providers.

TIER 3
means any medical provider which does not have a contract with the USC PPO Plan, Anthem Blue Cross Prudent Buyer or the BlueCard® program.

UCR/USUAL, CUSTOMARY AND REASONABLE CHARGES
means the customary fees charged by similar providers for the same services in similar circumstances and in the same or similar geographic area as determined by the Plan Administrator in its sole discretion. To the extent the Plan Administrator has delegated claims processing under the Plan to a vendor, that vendor shall have the same discretion as the Plan Administrator has under the Plan with respect to claims processing (including, but not limited to, UCR determination).

WEEKDAY
means a day of the week other than a Saturday, Sunday or legal holiday.
ELIGIBILITY AND ENROLLMENT

Eligible Employees

50% Full Time Eligibility

All benefits-eligible employees of the University who are scheduled to work at least 50% of full time (or work such 50% of full-time) are eligible for participation in the University’s health coverage program, except those covered by a collective bargaining agreement which does not provide for their participation in the University’s health coverage programs that applies to non-union represented employees.

Look-Back Period Eligibility

In addition to eligibility under the above, USC (“the University”) will also determine the benefits eligibility of certain employees by looking back at a defined period of twelve consecutive calendar months (the Look-Back Period), to determine whether during that measurement period the employee averaged at least 30 hours of service per week. If the employee were determined to be a full-time employee (as defined by the Affordable Care Act or “ACA”) during the Look-Back measurement period, then the employee would be treated as a full-time employee during a subsequent “stability period”, regardless of the employee’s number of hours of service during the stability period, so long as he or she remained an employee of the University. For an employee determined to be a full-time employee during the measurement period, the stability period would be a period of twelve consecutive calendar months that follows the measurement period and any related Administrative Period.

Measurement Periods

The University’s Standard Measurement Period will run from October 15th through October 14th (followed by an Administrative Period of October 15th to December 31st). This period will determine eligibility for January 1st open enrollment for a stability period beginning on that January 1st and ending on the following December 31st. In other words, the stability period for ongoing employees is the Plan Year (January 1st-December 31st).

The Initial Measurement Period for new variable, part-time or seasonal employees will start with the hire date, and will span a twelve month period followed by no more than a permitted Administrative Period and thereafter, a twelve month initial stability period.

Eligible Dependents

Eligible dependents are your legally married spouse or your Registered Domestic Partner, and your children less than 26 years of age (your children age 26 or older may be eligible if they qualify as a disabled dependent child under the requirements of the Plan as described below). New spouses must be enrolled within 30 days of the date of marriage. A copy of the marriage certificate must be submitted at the time of enrollment. Children are eligible from birth but must be enrolled within 90 days of birth. A copy of the birth certificate must be submitted at the time of enrollment.

Under the Plan a “child” does not include grandchildren or other relatives (such as nieces, nephews, aunts, uncles, brothers, sisters, etc.) and such persons are not eligible dependents under the Plan. Rather, “child” is limited to your natural children, stepchildren and children legally placed for adoption. A “dependent child” whose parents are divorced or legally separated is treated as a dependent of both parents for purposes of group health plan coverage under Section 105(b) of the Code.

Disabled dependents who are age 26 or older may be eligible for coverage if they qualify as your disabled dependent child. A disabled dependent child is someone who is 26 years of age or older who is totally and permanently disabled and incapable of self-support. At time of enrollment you must submit proof of disabled status from a Physician who will certify the dependent child’s total and permanent disability and incapacity for self-support. If the dependent child is currently enrolled in the Plan and then reaches the limiting age of 26, you must submit proof of disabled status 30 days before their 26th birthday in order to continue coverage. Otherwise, the dependent child will be terminated at the end of the month of their 26th birthday. The Plan will require proof of continued disabled status from time to time.
ENROLLING NEW DEPENDENTS — Continued

Enrolling New Dependents

Enrollment is not automatic. It requires an affirmative action (i.e., enrollment through the Workday Employee Self Service system adding your dependent(s)) within 30 days of the event (90 days for newborns).

If you do not apply for coverage within 30 days after the dependent(s) becomes eligible, you will be required to wait until the next annual open enrollment period to enroll your dependent(s). This means that your dependent(s) will not be eligible for health care benefits until January 1 of the following year. Certain Special Enrollment Rules apply, as outlined below.

Change in Family Status

Once you are in a medical plan, it is necessary that you notify the Office of Benefits Administration promptly if your family situation changes. Benefits Administration needs to know about birth or adoption, marriage or divorce, the death of your spouse or dependent or someone becoming eligible for Medicare. This will help establish when a dependent becomes eligible for coverage or when a dependent is no longer eligible. Status changes must be initiated through the Workday Employee Self Service system.

Special Enrollment Rules

The Health Insurance Portability and Accountability Act of 1996 provides additional enrollment opportunities for employees who initially waive coverage then subsequently experience a status change. See the USC Benefits website at https://benefits.usc.edu for additional information. Please contact the HR Service Center at (213) 821-8100 within 30 days of such status change to discuss the effect on your benefits. You will be required to provide documentation of the status change.

Eligible dependents who have other health coverage but subsequently lose that coverage, either because their COBRA coverage is exhausted or because they cease to be eligible for the other coverage, may be enrolled in the employee’s health plan within thirty (30) days of the loss of coverage. Documentation of other coverage and reason for loss, along with documentation of the dependent’s relationship to the employee must be provided. Enrollment in the employee’s health plan is not permitted if the dependent’s loss of coverage is due to failure to pay required premiums on a timely basis. You or your covered dependent may lose coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in conjunction with the Plan). Such loss of eligibility may be disclosed by a health plan to the USC benefits department as disenrollment for cause. A disenrollment of dependent or employee for cause from one USC health plan will result in loss of eligibility for enrollment in any other USC health plan.

Right to Receive and Release Information

As a condition of enrollment in this health plan and condition precedent to the provision of Benefits under this health plan, the USC PPO Plan, its agents, independent contractors and Participating Providers, in accordance with applicable law, shall be entitled to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Beneficiaries, which the Plan requires or is obligated to provide pursuant to legal process, Federal, State or Local law in the administration of this health plan. The Plan shall have the right to review any information and records including patient records of Beneficiaries pursuant to payment of a claim.

Eligibility Under the Hawaii Prepaid Health Care Law

Employees of the university eligible for coverage under the Hawaii Prepaid Health Care Law are not eligible under this self-funded Plan but rather under different insurance coverage issued to the university in accordance with, and to the extent required by, this Hawaii law.
PRIOR AUTHORIZATION PROGRAM

This is a pre-service review program which means that you must contact Anthem Blue Cross before receiving certain treatment and incurring expenses.

Failure to follow this program, as described in this booklet, may result in a reduction or denial of benefits, which may mean a greater expense to you.

Only services and supplies which are Medically Necessary will be covered as Eligible Expenses. For services and supplies found not to be Medically Necessary no Benefits will be paid under the Plan. Anthem Blue Cross will make a determination of Medical Necessity for services and supplies listed on the following page.

Non-Emergency Inpatient Admission

Including but not limited to Hospital admissions, elective inpatient surgeries, Skilled Nursing Facility Care and inpatient Hospice Care.

You or your Physician must request a review by Anthem Blue Cross for Medical Necessity. The request must meet these criteria:

a. It must be made by phone call to Anthem Blue Cross at (800) 274-7767 from you or your Physician on a weekday at least three (3) business days before the confinement starts.

b. It must include the facts required by Anthem Blue Cross for the review. If the request does not include all such facts, Anthem Blue Cross has the right to ask you or your Provider for them. The request for Medical Necessity review will not be considered complete unless Anthem Blue Cross receives the requested information by the end of the second weekday after Anthem Blue Cross asks.

If the above criteria are met, Anthem Blue Cross will inform the Provider and the facility of the number of days of Inpatient Confinement that Anthem Blue Cross approved as needed for care of the patient's condition. This will be confirmed by written notice sent to you, the Provider and the facility.

Emergency Hospital Admission

The rules for non-Emergency admission apply, except that:

a. The request for Anthem Blue Cross’ determination of Medical Necessity must be made by phoning (800) 274-7767 within 48 hours after the Hospital confinement starts.

b. The phone call may be made by the patient's Provider, the Hospital, the patient or a member of the patient's family.

Extension of Length of Inpatient Confinement

It may be possible to extend the number of days of Inpatient Confinement that Anthem Blue Cross had approved. You or the patient must arrange for the patient's Provider to request such an extension by phoning Anthem Blue Cross at (800) 274-7767 before the previously approved length of stay is over.

When the request is made, Anthem Blue Cross will make a new determination of Medical Necessity on the basis of information given by the Provider. The Provider will be informed as to how many more days, if any, that Anthem Blue Cross approves. This will be confirmed by written notice sent to you, the Provider and the facility.

Outpatient Services And Supplies

You or your Provider must request Anthem Blue Cross’ determination of Medical Necessity for prescribed outpatient invasive procedures and certain designated services and supplies. The request must meet these criteria:

- Requests must be made by phone call to Anthem Blue Cross at (800) 274-7767 from either you, your Provider or your care/service provider (e.g., physical therapist) on a weekday at least three (3) business days before you undergo the prescribed invasive procedure or obtain the prescribed service or supply.
The request must include the facts required by Anthem Blue Cross for the review. If the request does not include all such facts, Anthem Blue Cross has the right to ask you or your Provider for them. The request for determination of Medical Necessity will not be considered complete unless Anthem Blue Cross receives the requested information by the end of the second weekday after Anthem Blue Cross asks.

If the above criteria are met, Anthem Blue Cross will inform you, the prescribing Provider and the care/service provider of the result of the review. This will be confirmed by written notice sent to you, the prescribing Provider and the care/service provider.

Outpatient services and supplies and mental health treatment which require prior authorization by Anthem Blue Cross for Medical Necessity include:

- **Ambulance – Ground/Air/Water (in a non-medical emergency)**
  base charge, mileage and non-reusable supplies of a licensed air ambulance company used to transport a Covered Person in a non-medical emergency. The Prior Authorization Program will make every effort to obtain an agreed upon maximum of billed charges with the air/water ambulance company prior to authorizing.

- **Outpatient Surgical procedures**
  (Refer to page 14 for an example of what can be considered a surgical procedure)

- **Durable Medical Equipment, Prosthetics and Orthotics**
  purchase price or rental cost exceeding $2,000

- **Home Health Care services**
  including home infusion therapy

- **Hyperbaric Oxygen Therapy**

- **Physical and Occupational Therapy visits**
  after twelve (12) visits in one Calendar Year regardless of body treatment area (i.e., the annual limitation applies even if body treatment area is different)

- **All Cochlear Implants**

- **All Bariatric Surgeries** (No Benefits will be payable if prior authorization for Hospital Admission is not done by Anthem Blue Cross)

- **Mental Health**
  Partial hospitalization, Residential treatment center, and Intensive outpatient visits

- **Behavioral Health Treatment for Pervasive Developmental Disorders (ASD)**

- **Temporomandibular Joint Dysfunction treatment**
  when treatment is rendered by providers other than the USC Dental School, Faculty Practice providers

A prior authorization made by Anthem Blue Cross does not guarantee either payment of Benefits or the amount of Benefits. Eligibility for, and payment of, Benefits are subject to all of the terms of the coverage.

**Effect On Eligible Expenses When A Request For Prior Authorization Is Not Made On Time**

If a request for a prior authorization is not made in compliance with the procedures and time limits stated above, coverage for all treatment, services and confinement listed in this section may be reduced or denied.

Similarly, if an extension of Inpatient Confinement request is not made in compliance with the procedures above, coverage for all treatment, services and confinement listed in this section may be reduced or denied.

**Note:** It is your responsibility to ensure that a request for prior authorization is made on time.
The medical Benefit applies to the following Eligible Expenses for services and supplies furnished to you or your covered dependents for the treatment of injuries and sicknesses. Such services and supplies must be Medically Necessary and furnished in conjunction with the treatment of an injury or sickness incurred while you or your dependents are covered under the Plan. Regardless of any provision or statement below, a service or supply will NOT be covered unless it is Medically Necessary and also satisfies all other conditions and requirements of the Plan. Expenses are considered to be incurred on the date the service or supply is given or received. All expenses are subject to the applicable exclusions or limitations, deductibles, Copayments, Coinsurance, maximums and prior authorization provisions.

Acupuncture
See “Chiropractic / Acupuncture” services.

Ambulance Services / Emergency Medical Transportation
Emergency transportation by professional ambulance service (ground) is covered when Medically Necessary and required for Emergency Services. Ambulance services are covered only when it is not medically appropriate to transport the Covered Person by ordinary public or private vehicle.

The use of air and water ambulance services is covered when it is considered Medically Necessary and when all of the following criteria are met:

1. The ambulance must have the necessary equipment and supplies to address the needs of the individual; and
2. The individual’s condition must be such that any form of transportation other than by ambulance would be medically contraindicated; and
3. The individual’s condition is such that the time needed to transport by land poses a threat to the individual’s survival or seriously endangers the individual’s health; or the individual’s location is such that accessibility is only feasible by air or water transportation; and
4. The individual is transported to the nearest Hospital with appropriate facilities for treatment; and
5. There is a medical condition that is life threatening, including, but not limited to, the following:
   • Intracranial bleeding; or
   • Cardiogenic shock; or
   • Major burns requiring immediate treatment in a Burn Center; or
   • Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit; or
   • Multiple severe injuries; or
   • Transplants; or
   • Limb-threatening trauma; or
   • High risk pregnancy; or
   • Acute myocardial infarction; if this would enable the individual to receive a more timely medically necessary intervention (such as percutaneous transluminal coronary angioplasty [PTCA] or fibrinolytic therapy).

The use of air and water ambulance services to transport an individual from one Hospital to another requires that:

- The above criteria must be met, and
- The first Hospital does not have the required services and facilities to treat the individual.

The use of air and water ambulance services for deceased individuals is considered Medically Necessary when the above criteria are met and when either of the following is present:

1. The individual was pronounced dead while in route or upon arrival at the Hospital or final destination; or
COVERED SERVICES — Continued

2. The individual was pronounced dead by a legally authorized individual (physician or medical examiner) after the ambulance call was made, but prior to pick-up. In these circumstances the response to call is considered Medically Necessary.

However, where ground ambulance service would have sufficed, payment will be based on the amount payable to ground ambulance if such transportation would have been less costly.

Transportation, whether by ground ambulance or air/water ambulance, will only be covered to the nearest Hospital with appropriate facilities.

Non-Emergency (Scheduled) Ambulance Services

Ground, air and water ambulance services are also covered, when Medically Necessary, to transfer a Covered Person from one facility to another. All non-Emergency scheduled ambulance service is subject to Prior Authorization.

The charge must not exceed the recognized charge, as determined by the Claims Administrator, in its discretion.

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<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
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<tbody>
<tr>
<td>Network providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Ground Ambulance Services (Emergency)</td>
<td>Not available</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td>Air/Water Ambulance Services (Emergency)</td>
<td>Not available</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td>Ground/Air/Water Ambulance Services (Non-Emergency) Requires Prior Authorization</td>
<td>Not available</td>
<td>Plan payment shall be the least of: i. 80% of billed charges after deductible or ii. 100% of UCR</td>
</tr>
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Bariatric Surgery

The Plan covers inpatient or outpatient services for bariatric surgery only when performed at a Center of Medical Excellence in California or Blue Distinction Center for Specialty Care elsewhere in the United States.

Gastric bypass and gastric restrictive procedures are considered Medically Necessary for the treatment of clinically severe obesity for selected adults (18 years and older) who meet ALL the following criteria:

1. BMI of 40 or greater, or BMI of 35 or greater with an obesity-related co-morbid condition including, but not limited to:
   - diabetes mellitus; or
   - cardiovascular disease; or
   - hypertension; or
COVERED SERVICES — Continued

- life threatening cardio-pulmonary problems, (for example, severe obstructive sleep apnea, Pickwickian syndrome, obesity related cardiomyopathy); and

2. The individual must have actively participated in non-surgical methods of weight reduction; these efforts must be fully appraised by the physician requesting authorization for surgery; and

3. The physician requesting authorization for the surgery must confirm the following:
   - The individual's psychiatric profile is such that the candidate is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements; and
   - The candidate's post-operative expectations have been addressed; and
   - The individual has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate; and
   - The individual has undergone a preoperative mental health assessment and is felt to be an acceptable candidate; and
   - The individual has received a thorough explanation of the risks, benefits, and uncertainties of the procedure; and
   - The candidate's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling; and
   - The candidate's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.

Surgical repair following gastric bypass and gastric restrictive procedures is considered Medically Necessary when there is documentation of a surgical complication related to the original surgery, such as a fistula, obstruction, erosion, disruption/leakage of a suture/staple line, band herniation, or pouch enlargement due to vomiting.

Repeat surgical procedures for revision or conversion to another surgical procedure (that is also considered medically necessary within this document) for inadequate weight loss, (that is, unrelated to a surgical complication of a prior procedure) are considered Medically Necessary when ALL the following criteria are met:

- The individual continues to meet all the medical necessity criteria for bariatric surgery; and
- There is documentation of compliance with the previously prescribed postoperative dietary and exercise program; and
- 2 years following the original surgery, weight loss is less than 50% of pre-operative excess body weight and weight remains at least 30% over ideal body weight (taken from standard tables for adult weight ranges based on height, body frame, gender and age, an example is available from the National Heart Lung and Blood Institute (NHLBI) at: http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm).
### COVERED SERVICES — Continued

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<th>TIER 1</th>
<th>TIER 2</th>
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<tbody>
<tr>
<td>All Hospital admissions are subject to the Prior Authorization Program. No Benefits will be payable if prior authorization for Hospital admission is not done by Anthem Blue Cross.</td>
<td>Keck Hospital of USC, a Center of Medical Excellence (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Center of Medical Excellence in California / Blue Distinction Center Elsewhere in the U.S.</td>
<td>Non-Network Providers</td>
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<tr>
<th>Inpatient Room and Board</th>
<th>Plan pays 100%</th>
<th>Plan pays 100% after Copay You pay a $300 Copay per admission</th>
<th>Not Covered</th>
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<tr>
<th>Outpatient Surgery Facility</th>
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<tr>
<td>Network providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Plan pays 100%</td>
<td>Plan pays 100% after Copay You pay a $200 Copay per admission</td>
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<th>Surgeon</th>
<th>Plan pays 90% after deductible You pay 10% after deductible</th>
<th>Plan pays 80% after deductible You pay 20% after deductible</th>
<th>Plan pays 50% of UCR after deductible, up to a maximum of $3,200 You pay remainder of charges</th>
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<tr>
<th>Assistant Surgeon</th>
<th>Plan pays 90% after deductible You pay 10% after deductible</th>
<th>Plan pays 80% after deductible You pay 20% after deductible</th>
<th>Plan pays 50% of UCR after deductible, up to a maximum of $1,600 You pay remainder of charges</th>
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<tr>
<th>Anesthesiologist</th>
<th>Plan pays 90% after deductible You pay 10% after deductible</th>
<th>Plan pays 80% after deductible You pay 20% after deductible</th>
<th>Plan pays 50% of UCR after deductible, up to a maximum of $1,500 You pay remainder of charges</th>
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</thead>
</table>

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<tr>
<th>Imaging, Tests and Lab Work</th>
<th>Plan pays 90% after deductible You pay 10% after deductible</th>
<th>Plan pays 80% after deductible You pay 20% after deductible</th>
<th>Plan pays 50% of UCR after deductible You pay remainder of charges</th>
</tr>
</thead>
</table>

### Breast Pumps

Rental or purchase of a breast pump is covered at 100% of contracted rate with Tier 1 and Tier 2 providers. The purchase or rental with Tier 3 providers will be covered at billed charges, up to the greater of 100% of UCR or $700 (e.g., over-the-counter retail or through non-contracted DME provider).

Tier 3 claims will only be made for the total purchase or rental price of the breast pump after purchase/delivery. For Tier 3 claims, no interim payments or partial services will be paid. Coverage excludes any additional fees such as credit card fees, layaway fees, etc. Any breast pump purchased or rented through a Tier 3 provider will require you to pay upfront and submit a claim form for reimbursement, along with the original receipt, identifying product purchased as a breast pump.
COVERED SERVICES — Continued

Regardless of provider Tier level, all breast pumps are limited to one (1) per Calendar Year, unless the Plan receives written medical necessity justification from your Physician.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
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<tr>
<td>(see “Definitions – Tier 1”)</td>
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<table>
<thead>
<tr>
<th>Breast Pumps</th>
<th>Limited to one (1) pump per Calendar Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 100% of contracted rate</td>
<td>Plan pays billed charges, up to the greater of 100% of UCR or $700</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast Pump Supplies</th>
<th>Plan pays 100% of contracted rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays billed charges, up to the greater of 100% of UCR or $700</td>
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</tbody>
</table>

**Chiropractic / Acupuncture Services**

The maximum combined Benefit per Calendar Year for chiropractic and acupuncture services is limited to a maximum of 40 visits in a Calendar Year. Chiropractic and acupuncture services do not require prior authorization and do not require a Physician prescription.

The Plan will pay participating chiropractors and acupuncturists at the rate of 80% after deductible (Tier 2) and Non-Network providers (Tier 3) will be covered at 50% of UCR after deductible. You may go on-line to view a listing of Tier 2 providers at www.anthem.com/ca.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
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<tbody>
<tr>
<td>Network Providers</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>(see “Definitions – Tier 1”)</td>
<td>(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Chiropractic/ Acupuncture Services</th>
<th>Chiropractic and Acupuncture services are limited to a combined maximum of 40 visits in a Calendar Year.</th>
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</thead>
<tbody>
<tr>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
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</table>
COVERED SERVICES — Continued

**Cochlear Implants**

Cochlear implants are covered with Prior Authorization by Anthem Blue Cross.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>Anthem Blue Cross Prudent</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>(see “Definitions – Tier 1”)</td>
<td>Buyer/BlueCard® Providers</td>
<td></td>
</tr>
<tr>
<td>(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cochlear Implants</th>
<th>All cochlear implants are subject to the Prior Authorization Program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit</td>
<td>Plan pays 100% after Copay  You pay a $20 Copay</td>
</tr>
<tr>
<td>Surgeon, surgical assistants and anesthesiologists</td>
<td>Plan pays 90% after deductible  You pay 10% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery Facility</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100% after Copay  You pay a $200 Copay</td>
</tr>
<tr>
<td></td>
<td>Plan pays 50% of UCR after deductible  You pay remainder of charges</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% after deductible  You pay 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 50% of UCR after deductible  You pay remainder of charges</td>
</tr>
<tr>
<td></td>
<td>Plan pays 50% of UCR, up to a maximum of $2,700  You pay $600 Copay plus remainder of charges</td>
</tr>
</tbody>
</table>

**Dental Coverage**

The Plan does not cover services or X-ray examinations in connection with mouth conditions due to periodontal disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue. However, the Plan does cover the following treatment at 90% after deductible when services are rendered at the USC Faculty Practice at the USC Oral Health Center, 80% after deductible for any Tier 2 provider and 50% of UCR after deductible for any Tier 3 provider:

a. Temporomandibular Joint Dysfunction treatment, when determined in advance by Anthem Blue Cross that treatment is Medically Necessary. (No prior authorization required when services are being provided by a Tier 1 provider.)

b. Accidental dental treatment: covered up to one (1) year after accident. The Plan will provide coverage only when the individual’s dental insurance maximum is reached. The Plan will not cover the dental insurance deductible or the dental coinsurance payments. Eligible Expenses include, but are not limited to: treatment by a Physician, dentist, or oral surgeon of injuries to natural teeth including replacement of such teeth, and related X-rays. The charges for these services will be considered to be Eligible Charges under the Plan, but paying after payment by your dental insurance, if any.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>USC Faculty Practice at USC Oral Health Center</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Services</th>
<th>USC Faculty Practice at USC Oral Health Center</th>
<th>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporomandibular Joint Dysfunction</td>
<td>Plan pays 90% after deductible  You pay 10% after deductible</td>
<td>Plan pays 80% after deductible  You pay 20% after deductible</td>
<td>Plan pays 50% of UCR after deductible  You pay remainder of charges</td>
</tr>
</tbody>
</table>
### COVERED SERVICES — Continued

<table>
<thead>
<tr>
<th><strong>Accidental Dental Treatment</strong></th>
<th><strong>TIER 1</strong></th>
<th><strong>TIER 2</strong></th>
<th><strong>TIER 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered up to one year following accidental injury to the teeth. The Plan will provide coverage only when the individual’s dental insurance maximum is reached and will not cover dental insurance deductible, coinsurance or copayment amounts.</td>
<td>USC Faculty Practice at USC Oral Health Center</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
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<tr>
<td>You pay 10% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay remainder of charges</td>
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</table>

### Diabetic Equipment and Supplies

The Plan covers the following services and supplies:
- Blood glucose monitors
- Insulin pumps and insulin pump supplies

<table>
<thead>
<tr>
<th><strong>Diabetic Equipment and Supplies</strong></th>
<th><strong>TIER 1</strong></th>
<th><strong>TIER 2</strong></th>
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<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
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<tr>
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<td>Plan pays 50% of UCR after deductible</td>
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<tr>
<td>You pay 10% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay remainder of charges</td>
<td></td>
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</tbody>
</table>

The following diabetic supplies are covered by the **Prescription Drug Program**:
- Test strips and solutions for blood glucose monitors
- Visual reading and urine testing strips
- Injection aids, syringes, lancets, automatic lancing devices, drawing up devices
- Medications for treatment of diabetes

### Disposable Medical Supplies

The Plan covers supplies needed to operate or use covered Durable Medical Equipment, prosthetics or orthotics.

<table>
<thead>
<tr>
<th><strong>Disposable Medical Supplies</strong></th>
<th><strong>TIER 1</strong></th>
<th><strong>TIER 2</strong></th>
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<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
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<tr>
<td>Plan pays 90% after deductible</td>
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<td>Plan pays 50% of UCR after deductible</td>
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<tr>
<td>You pay 10% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay remainder of charges</td>
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</tbody>
</table>
COVERED SERVICES — Continued

Durable Medical Equipment, Prosthetic and Orthotic Devices

Durable Medical Equipment (DME), prosthetic and orthotic devices are covered by the Plan when Medically Necessary and prescribed by a Physician.

DME includes medical equipment and supplies which are of no further use when medical needs end, for the exclusive use of the patient, not primarily for comfort or hygiene, not for environmental control or for exercise and manufactured specifically for medical use (e.g., wheelchairs, crutches, traction equipment, blood glucose machines, etc.).

Where two or more alternative devices are appropriate to treat a Covered Person’s condition, the most cost effective device will be covered as determined by Anthem Blue Cross, in its discretion, at the time of rental/purchase. The Plan shall have no obligation to replace that device while it remains functional despite normal wear and tear, notwithstanding any subsequent improvements in the design of the product.

Wheelchairs provided as a covered service under this Plan are limited to standard wheelchairs. However, the Plan will provide coverage for a motorized wheelchair if it is determined by Anthem Blue Cross that it is Medically Necessary and a standard wheelchair would not meet the basic functional requirements. Additionally, if a Covered Person wishes to have a non-standard wheelchair that is not Medically Necessary, this Plan will apply the amount of money it would have had to pay for a standard wheelchair to the coverage for the non-standard wheelchair. The Covered Person would then be fully responsible for the difference remaining on the non-standard wheelchair.

External orthotic and external prosthetic devices are limited to those devices that are affixed to the body externally and which are ordered by a Physician to support a defect of form or function of a permanently inoperative or malfunctioning body part (e.g., occlusal splint and communication devices such as voice boxes, but not including such unaffixed devices as voice-activated computers, etc.).

The Plan covers external prosthetics when Medically Necessary, including:

- Artificial limbs or eyes, when FDA approved and not considered Experimental or Investigational,
- Breast prostheses following a mastectomy,
- Cranial cold cap, and
- Wigs prescribed by a Physician as a prosthesis for hair loss due to injury, disease, or treatment of a disease, up to $1,000 per Covered Person, within a 24-month period.

Repairs of prosthetic devices are covered when the repair will cost less than the cost of replacing the device.

The Plan covers internal prosthetics, including (but not limited to) the following, when Medically Necessary and surgically implanted:

- Electronic heart pacemakers, intraocular lenses and joints, and
- Post-operative breast prostheses following a mastectomy. See Reconstructive Surgery and Women’s Health Rights for more information.

**DME, prosthetic and orthotic devices with a purchase price or rental cost exceeding $2,000 must have prior authorization by Anthem Blue Cross.** Rental charges which exceed the reasonable purchase price of the equipment are not covered. If purchase is required, the Beneficiary will be notified. After notification, the Plan will discontinue rental authorization.

The Benefit level for DME, prosthetic and orthotic devices will be based on Medical Necessity. This Plan does not apply the allowable cost of covered devices toward services and supplies that are not covered devices.

Convenience, luxury items and features are not covered.
### COVERED SERVICES — Continued

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
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<tr>
<td><strong>Network Providers</strong>&lt;br&gt;(see “Definitions – Tier 1”)&lt;br&gt;(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td></td>
<td></td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td><strong>Prescribed Durable Medical Equipment, Prosthetic and Orthotic Devices</strong></td>
<td>Purchase price or rental cost over $2,000 requires prior authorization.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Plan pays 90% after deductible&lt;br&gt;You pay 10% after deductible</td>
<td>Plan pays 80% after deductible&lt;br&gt;You pay 20% after deductible</td>
<td>Plan pays 50% of UCR after deductible&lt;br&gt;You pay remainder of charges</td>
</tr>
<tr>
<td><strong>Wigs</strong></td>
<td>Plan pays 80% of billed charges after deductible, up to $1,000 within a 24-month period</td>
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### Emergency Services

For services to be considered Emergency Services, they must fall within the definition of “Emergency Services” set forth on page 9 and be rendered in a Hospital Emergency Department.

If you seek services at an Emergency Department and **are not** admitted as inpatient, services will be considered Outpatient Emergency Services and a $200 Copayment will apply.

If you are admitted as an inpatient directly from the Hospital’s Emergency Department, the $200 Outpatient Emergency Department Copayment will be waived and the inpatient Hospital Copay will apply.

For inpatient Hospital Emergency Services at a Non-Network Hospital (Tier 3), you will be responsible for a $300 per admission inpatient Hospital Copay and 20% of billed charges. All Tier 3 Physician/provider services will be covered at 80% of billed charges after deductible and you will be responsible for 20% of billed charges. The Tier 3 medical out of pocket maximum will apply. These same responsibilities apply to a Covered Person under 19 years of age admitted to a Tier 3 Hospital through the Emergency Department.
COVERED SERVICES — Continued

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<th>TIER 1</th>
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<td>Network Providers*&lt;br&gt;(see “Definitions – Tier 1”)&lt;br&gt;(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
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</table>

**Outpatient Emergency Department Services**

- Hospital: Only available at USC Verdugo Hills Hospital<br>Plan pays 100% after Copay<br>You pay a $200 Copay per visit (Copay waived if admitted directly to Hospital) - Plan pays 100% after Copay<br>You pay a $200 Copay per visit (Copay waived if admitted directly to Hospital) - Plan pays 100% of billed charges

**Physician**

- Only USC Faculty at USC Verdugo Hills Hospital<br>Plan pays 100% - Plan pays 100% of billed charges

**Inpatient Emergency Services**

- Room and Board: Available only at USC Verdugo Hills Hospital<br>Plan pays 100% - Plan pays 100% after Copay<br>You pay $300 Copay per admission - Plans pays 80% of billed charges after Copay<br>You pay $300 Copay per admission plus 20% of billed charges

**Physician**

- Plan pays 90% after deductible<br>You pay 10% after deductible - Plan pays 80% after deductible<br>You pay 20% after deductible - Plan pays 80% of billed charges after deductible<br>You pay 20% of billed charges

*LAC/USC Medical Center is a Tier 3 provider, not a Tier 1 provider.

**Gender Reassignment Surgery**

The Plan covers inpatient or outpatient charges submitted by a Hospital or a physician for Medically Necessary gender reassignment surgery and fulfillment of prerequisites to qualify for the surgery. Prior Authorization by Anthem Blue Cross for gender reassignment surgery is required.

Gender reassignment surgery presents significant medical and psychological risks, and the results are irreversible. Therefore, subject to 45 CFR 92.207, the following are prerequisites to any gender reassignment surgery:

- The individual is at least 18 years of age.
- The individual has capacity to make fully informed decisions and consent for treatment.
- The individual must be free of severe psychiatric disorders.
- The individual has been diagnosed with gender dysphoria exhibiting:
  - The desire to live and be accepted as a member of the opposite sex
  - The transsexual identity has been present persistently for at least two years
  - The disorder is not a symptom of another mental disorder; and
  - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician.
- The individual engages in 12 continuous months of living in a gender role that is congruent with their gender identity.
- Two referrals from qualified mental health professionals who have independently assessed the individual.
COVERED SERVICES — Continued

Gender reassignment surgery is considered not Medically Necessary when one or more of the above criteria have not been met. In addition, cosmetic procedures that are not considered Medically Necessary include:

- Reduction thyroid chondroplasty
- Liposuction
- Rhinoplasty
- Facial bone reconstruction
- Face lift
- Blepharoplasty
- Voice modification surgery
- Hair removal/hairplasty
- Breast augmentation

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<tbody>
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<tr>
<td>(includes Tier 2 providers for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Persons &lt; 19 years of age)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment Surgery</td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of UCR after Copay</td>
</tr>
<tr>
<td>Inpatient Room and Board</td>
<td></td>
<td>You pay a $600 Copay per admission</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of UCR, up to a maximum of $2,700</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You pay $600 Copay plus remainder of charges</td>
</tr>
<tr>
<td>Outpatient Surgery Facility</td>
<td>Plan pays 100%</td>
<td></td>
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<tr>
<td></td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
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<td></td>
<td>You pay 10% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
<tr>
<td>Imaging, Tests and Lab Work</td>
<td>Plan pays 90% after deductible</td>
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<tr>
<td></td>
<td>You pay 10% after deductible</td>
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</tbody>
</table>

**Hearing Aids For Dependent Children Under Age 26**

Hearing aids limited to Covered Persons who are dependent children under age 26 will be covered for the Usual, Reasonable and Customary cost of 1 hearing aid every 36 months for each hearing impaired ear. Where two or more alternative hearing aids are appropriate, only the most cost effective hearing aid, as determined by the Plan Administrator in its discretion, will be covered. The hearing aid must be prescribed, fitted and dispensed by a licensed audiologist. You may choose to purchase a more expensive hearing aid for a covered child under age 26 and pay the difference to the hearing aid provider.
COVERED SERVICES — Continued

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
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<td>Non-Network Providers</td>
</tr>
</tbody>
</table>

### Hearing Aids

- Maximum of one (1) hearing aid every 36 months for each hearing-impaired ear.
  - Plan pays 90% after deductible
  - You pay 10% after deductible
  - Plan pays 50% of UCR after deductible
  - You pay remainder of charges

### Home Health Care

Home Health Care coverage provides Benefits for Eligible Charges for care furnished by a Home Health Care Agency or visiting nurse association.

Any treatment plan in excess of ten (10) visits must be submitted in writing for prior authorization by Anthem Blue Cross.

Medically Necessary skilled care furnished by a Home Health Agency or visiting nurse association is covered, up to one hundred (100) visits per Calendar Year.

Covered Services include full-time, part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse or licensed occupational therapist, physical therapist or speech therapist in the home. (Speech Therapy is subject to the limitations provided in the Benefit description for Speech Therapy described on page 47.)

Covered Services must be:

1. prescribed by the patient’s physician;
2. for skilled care only and not for custodial care, and;
3. for the continued treatment of an injury or illness.

A visit of four (4) hours or less by any one individual provider, shall be considered as one Home Health visit.

Skilled nursing visits, including skilled nursing visits in association with home infusion services, in excess of ten (10) visits in a Calendar Year must have prior authorization by Anthem Blue Cross. These visits are included under the Home Health Care Benefit and limited to a total combined Benefit of one hundred (100) visits per Calendar Year.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
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</tr>
</tbody>
</table>

### Home Health Care including Home Infusion Therapy

- Any treatment plan in excess of ten (10) visits must be submitted in writing for prior authorization by Anthem Blue Cross. The Plan covers up to one hundred (100) visits per person per Calendar Year.
  - Plan pays 90% after deductible
  - You pay 10% after deductible
  - Plan pays 80% after deductible
  - You pay 20% after deductible
  - Plan pays 50% of UCR after deductible
  - You pay remainder of charges
COVERED SERVICES — Continued

Home Infusion Therapy
The following are Covered 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, 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 under this benefit;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. 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 defined above); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient’s response to therapy regimen.

Hospice Care
The Hospice Benefit coverage pays for charges incurred for a terminally ill person while in a Hospice Care Program. The Benefits will be paid if the Hospice Services or the Hospice stay is:

1. provided while the terminally ill person is a Covered Person;
2. ordered by the supervising Physician as part of the Hospice Care Program;
3. charged for by the Hospice Care Program; and
4. provided within 6 months of the terminally ill person's entry or re-entry (after a remission period) in the Hospice Care Program.

All periods of care in a Hospice Care Program will be considered related and to have occurred in the one period of care unless separated by at least 3 consecutive months.

Exclusions Under the Hospice Care Benefit
The following charges are not covered:

1. Charges incurred during a remission period. This applies if, during remission, the terminally ill person is discharged from the Hospice Care Program.
2. Charges for services provided by yourself, spouse, or a child, brother, sister, or parent of yourself or spouse.
3. Charges for funeral arrangements.
4. Charges for pastoral counseling.
5. Charges for financial or legal counseling, including estate planning and the drafting of a will.

Extension of Benefits
Under certain circumstances, Hospice Care Benefits will be available for 30 days after the termination of coverage if a Covered Person is participating in a Hospice Care Program at the time the coverage ends. This extension of Benefits will apply only to Hospice Care Program expenses. Extension of Benefits requires Prior Authorization by Anthem Blue Cross.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Not Available</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 50% of UCR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You pay remainder of charges (Deductible waived)</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

**Hospital Services**

Subject to all the provisions of the Plan (including, but not limited to the Prior Authorization Program), the Plan covers Medically Necessary charges made by a Hospital for room and board and other Hospital services and supplies when you are confined as an Inpatient. The level of such coverage is described on the following table. Eligible Expenses for Medically Necessary room and board charges are subject to a maximum daily limit equal to the hospital’s standard semi-private room rate.

If confinement in a private room in a Hospital for a reason other than Medically Necessary isolation of the patient, the Eligible Expenses for room and board are subject to a daily limit equal to the Hospital's standard semi-private room rate.

*Remind your health care provider that prior authorization is required for all Hospital admissions.*

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Hospital Expenses</th>
<th>All Hospital admissions are subject to the Prior Authorization Program.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>Plan pays 100%</td>
<td>Plan pays 100% after Copay You pay a $300 Copay per admission</td>
<td>Plan pays 50% of UCR after Copay You pay a $600 Copay per admission plus all charges above 50% of UCR</td>
</tr>
<tr>
<td>Physician Visits</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charge</td>
</tr>
<tr>
<td>Imaging, Tests and Lab Work</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charge</td>
</tr>
</tbody>
</table>

**Infusion Therapy**

The Plan covers Medically Necessary charges for the following outpatient infusion therapy services and supplies:

- Pharmaceuticals administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy
- Professional services
- Chemotherapy
- Dialysis
- Drug therapy (includes antibiotic and antivirals)

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

Laboratory Services
The Plan covers Medically Necessary laboratory services and pathology tests to diagnose an illness or injury.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Laboratory Services (Inpatient/Outpatient)</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
</tbody>
</table>

Breast and Ovarian Cancer (BRCA) Testing
BRCA testing is molecular susceptibility testing for breast and ovarian cancer. BRCA testing is considered Medically Necessary for women who are in high risk categories.

LiveHealth Online Consultation
Primary care physician visits may be conducted online via a two-way video consultation. LiveHealth Online physicians (general practitioners, family medicine, internists, and pediatricians) are available year round, seven days a week, 24 hours a day.

LiveHealth Online physicians can answer questions, make a diagnosis, and even prescribe basic medications when needed and as legally permitted in certain states*. A transcript of the LiveHealth Online consultation will be sent to your primary care physician upon request.

Common conditions addressed in a LiveHealth Online consultation include, but are not limited to:

- Cough
- Cold
- Minor rashes
- Allergies
- Ear pain
- Fever
- Flu
- Headache
- Pink Eye

You may access this service by visiting www.livehealthonline.com. Information on system requirements and supported mobile devices are located on the website.

LiveHealth Online consultations are covered as follows:

<table>
<thead>
<tr>
<th>TIER 2</th>
<th>LiveHealth Online Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>LiveHealth Online Consultation</td>
<td>Plan pays 100% after Copay You pay a $20 Copay if the patient is less than 19 years of age You pay a $30 Copay if the patient is 19 years of age and older</td>
</tr>
</tbody>
</table>

* To discover where LiveHealth Online is available, visit www.livehealthonline.com/availability.html. In addition, you may refer to this website to determine if you reside in a state that does not allow LiveHealth Online physicians to prescribe medication. California residents are able to obtain prescriptions from a LiveHealth Online physician as appropriate.
COVERED SERVICES — Continued

Maternity Care
Maternity care is covered as any other medical condition and as required by law. Coverage includes:

- Normal pregnancy and
- Complications of pregnancy.

The Plan covers prenatal, delivery and postnatal maternity care. For inpatient care of the mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery, and
- 96 hours after a cesarean section.

Prior authorization from Anthem Blue Cross is required only for in-home uterine monitoring.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>(see “Definitions – Tier 1”)</td>
<td>(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td></td>
</tr>
<tr>
<td>Maternity Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>Plan pays 100% after Copay You pay a $20 Copay per visit</td>
<td>Plan pays 100% after Copay You pay a $30 Copay per visit</td>
</tr>
<tr>
<td>Physician Delivery</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td>Anesthesiologists, Surgical Assistants</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td>Hospital Room and Board</td>
<td>(Available only at USC Verdugo Hills Hospital) Plan pays 100%</td>
<td>Plan pays 100% after Copay You pay a $300 Copay per admission You pay $100 Copay per admission only at Good Samaritan Hospital when delivery is done by a USC Care Medical Group Obstetrician</td>
</tr>
</tbody>
</table>

Mental Health And Substance Abuse Program
Prior authorization is not required for outpatient visits, except for intensive outpatient visits.

Inpatient admissions, partial hospitalization, and residential treatment center require Prior authorization, to the extent permitted by law. Refer to the Prior Authorization Program on pages 17-18.

Inpatient Care
The Plan covers Hospital inpatient (residential) services when your condition requires Medically Necessary services that are available only in an inpatient setting. Coverage includes:

- Room and board charges, up to the facility’s semi-private room rate and
- Other necessary services and supplies
COVERED SERVICES — Continued

Treatment Facility
The Plan covers inpatient care in a treatment facility such as an acute inpatient facility or a residential treatment center.

Partial Hospitalization/Confinement
The Plan covers charges made by a hospital or psychiatric hospital/facility for partial confinement treatment through a day care or night care treatment program. Care is covered only if the condition requires treatment that is available only in a partial confinement treatment setting or if you would need inpatient care if you were not participating in this type of program.

Outpatient Treatment
The Plan also covers Medically Necessary treatment of substance abuse and/or mental disorders on an outpatient basis.

<table>
<thead>
<tr>
<th>Mental Health/ Substance Abuse</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
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<tr>
<td>(see “Definitions – Tier 1”)</td>
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</tr>
<tr>
<td>(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Room and Board</td>
<td>Plan pays 100%</td>
<td>Plan pays 100% after Copay</td>
<td>Plan pays 50% of UCR after Copay</td>
</tr>
<tr>
<td></td>
<td>You pay a $300 Copay per admission</td>
<td>You pay a $600 Copay per admission plus all charges above 50% of UCR</td>
<td></td>
</tr>
<tr>
<td>Physician Visits (Inpatient)</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
<tr>
<td></td>
<td>You pay 10% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
<tr>
<td>Physician Visits (Outpatient)</td>
<td>Plan pays 100% after Copay</td>
<td>Plan pays 100% after Copay</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
<tr>
<td></td>
<td>You pay a $20 Copay per visit</td>
<td>You pay a $30 Copay per visit</td>
<td>You pay remainder of charges</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan pays 100%</td>
<td>Plan pays 100% after Copay</td>
<td>Plan pays 50% of UCR, up to a maximum of $2,700</td>
</tr>
<tr>
<td></td>
<td>You pay a $200 Copay per admission</td>
<td>You pay a $600 Copay per admission plus remainder of charges</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
<tr>
<td></td>
<td>You pay 10% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
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</tbody>
</table>
COVERED SERVICES — Continued

Nutritional Services
Nutrition evaluation and counseling are covered, when prescribed by a Physician, for medical management of:

- A documented organic disease (high cholesterol, diabetes, allergies and hypertension)
- Anorexia Nervosa or Bulimia Nervosa

<table>
<thead>
<tr>
<th>TIER 1</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td><strong>Nutritional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
<tr>
<td>You pay 10% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
</tbody>
</table>

All other services for the purpose of diet control and weight reduction are not covered, except as required by law or otherwise provided under the Plan.

Outpatient Surgery – Hospital-Based or Freestanding Facility
Outpatient surgical procedures require prior authorization by Anthem Blue Cross.

The Plan covers outpatient surgery in:

- A surgery center or
- The outpatient department of a hospital

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the Hospital, surgery center or office-based surgical facility on the day of the procedure and
- The operating Physician’s services for performing the procedure, related pre- and post-operative care and the administration of anesthesia

The Plan does not cover the services of a Physician who renders technical assistance to the operating Physician.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td><strong>Outpatient Surgery Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of UCR, up to a maximum of $2,700</td>
</tr>
<tr>
<td></td>
<td>You pay a $200 Copay per admission</td>
<td>You pay a $600 Copay per admission plus remainder of charges</td>
</tr>
<tr>
<td>Physician</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
<tr>
<td></td>
<td>You pay 10% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
<tr>
<td>Imaging, Tests and Lab Work</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% of UCR after deductible</td>
</tr>
<tr>
<td></td>
<td>You pay 10% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
<tr>
<td></td>
<td>Plan pays 20% after deductible</td>
<td>You pay remainder of charges</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

The Non-Network outpatient surgery facility Benefit will not exceed a maximum of $2,700. You will be responsible for the remainder of the charges.

Physical And Occupational Therapies
Benefits for a Network Physical or Occupational therapist's services will be payable at the rate of 100% after a $20 Copay per visit (Tier 1) and 100% after a $30 Copay per visit (Tier 2). If Non-Network providers (Tier 3) are used, the rate of payment will be 50% of UCR after deductible.

Twelve (12) visits per Calendar Year are allowed for each, physical and occupational therapy (not combined) without prior authorization. Regardless of body treatment area, physical or occupational therapy services in excess of twelve (12) visits per Calendar Year require review and prior authorization by Anthem Blue Cross. Call (800) 274-7767 for information. No payment will be made for visits in excess of twelve (12) within a Calendar Year without prior authorization.

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Physical and Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Inpatient Visit</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
</tr>
<tr>
<td>Outpatient Visit</td>
<td>Plan pays 100% after Copay You pay $20 Copay per visit</td>
<td>Plan pays 100% after Copay You pay a $30 Copay per visit</td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
</tr>
</tbody>
</table>

Physician Visits
Physician visits, when Medically Necessary, will be covered as follows:

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Physicians</td>
<td>Outpatient Expenses (Physician Office Visit)</td>
<td></td>
</tr>
<tr>
<td>Plan pays 100% after Copay You pay a $20 Copay per visit</td>
<td>Plan pays 100% after Copay You pay a $30 Copay per visit</td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
<td></td>
</tr>
<tr>
<td>Imaging, Tests and Lab Work</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

Prescription Drug Program
This Plan provides Benefits for certain drugs prescribed by a Physician for an injury or illness and dispensed by a pharmacy, or other entity licensed to dispense prescription drugs.

- The amount of the drug which may be dispensed per prescription or refill must be in quantities normally prescribed and limited to a one month supply.
- Prescriptions requiring greater amounts must be completed on a refill basis, except those listed under the maintenance drug section herein.

The Plan will pay the charge in excess of the Copayment for each covered prescription or refill, filled by a Network pharmacy.

Note: The Plan does not cover deductibles, copayments, or coinsurance amounts due under any other prescription drug plan. For example, if you are covered under a spouse’s plan, this Plan does not cover your prescription drug copayments under your spouse’s plan.

Prescription Drug Copayment
The retail Copayment for each prescription drug filled at a Network pharmacy for each 30-day supply is:

- **Generic** – $10 Copay
- **Brand** (no Generic available) – 20% coinsurance, with a minimum Copay of $30 and a maximum Copay of $125
- **Brand** (with Generic available) – 50% of cost, with a minimum Copay of $50 – **No Maximum Copay**
- **Specialty Drug** (Brand - no Generic available) – 20% coinsurance, with a minimum Copay of $30 and a maximum Copay of $125
- A $0 Copay for over-the-counter (OTC) **non-sedating antihistamines, proton pump inhibitors and nasal corticosteroids** when dispensed pursuant to a prescription written by a Physician. (Refer to the Mandatory Step Therapy section on the following page for details.)

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>MedImpact Network Pharmacy</th>
<th>Non-Network Pharmacy</th>
</tr>
</thead>
</table>
| Retail (up to a 30-day supply) | **Generic**: $10 Copay  
**Brand** (no Generic available): 20% Coinsurance  
($30 minimum Copay / $125 maximum Copay)  
**Brand** (with Generic available): 50% of cost  
($50 minimum Copay / No maximum Copay)  
**Specialty Drug** (Brand - no Generic available): 20% Coinsurance  
($30 minimum Copay / $125 maximum Copay) | Plan pays 50% of the National MedImpact Value rate (not of cost)  
You pay remainder of charges |
| Mail Order (up to a 90-day supply) | Same Copays as retail, but Copay amounts apply to each 30-day supply | Not Covered |
| Prescription Out-of-Pocket Limits (Per Calendar Year) | **$4,850 maximum for an individual**  
**$7,200 maximum for two or more individuals within a family** | No Out-of-Pocket maximum |
COVERED SERVICES — Continued

For prescriptions filled at a non-Network pharmacy, the Plan will reimburse up to 50% of the Plan’s National MedImpact Value rate. Prescriptions filled at a non-Network pharmacy must be paid in full by the Covered Person at the time of service. For reimbursement the Covered Person must submit a prescription claim form within 60 days of the fill.

For drugs dispensed in excess of a one month’s supply, multiple Copayments will be charged.

Mandatory Step Therapy

The Plan has a mandatory Step Therapy in place for Antihistamines, Proton Pump Inhibitors (PPI), and Nasal Corticosteroids. What this means is that you must first fill a generic/over the counter (OTC) medication at a $0 Copay before a Brand name prescription under these three categories will be covered by the Plan. The following is a list of the generic/OTC medications that are covered at $0 Copay with a written prescription from your Physician:

**Antihistamines:** cetirizine, cetirizine OTC, fexofenadine, fexofenadine-pseudoephedrine, levocetirizine, loratadine OTC, Alavert, Alavert-D, Allegra OTC, Allegra-D OTC, Claritin OTC, Claritin-D 12 HR, and Zyrtec OTC.

**PPIs:** esomeprazole OTC, omeprazole, omeprazole OTC, omeprazole-sodium bicarbonate (requires clinical prior authorization), pantoprazole, lansoprazole, lansoprazole ODT, Nexium OTC, Prevacid OTC, Prilosec OTC, and Zegerid OTC.

**Nasal Corticosteroids:** Flonase OTC, Nasacort OTC, and Rhinocort OTC.

Mail Order

A mail order service is available for maintenance medications up to a 90 day supply of medication, as long as the prescription is written for a 90 day supply. The Copay is the same as retail, but Copay amounts apply to each 30 day supply of medication.

Maintenance Medications

Certain maintenance medications may be dispensed in a larger than 30 day supply as long as the Physician prescribes it. Categories of drugs which may be dispensed in up to a three (3) month supply include:

- Antiarthritics
- Antiasthmatics
- Antiparkinson drugs
- Anticlotting drugs
- Antidepressants
- Antiepileptic drugs
- Antihypertensives
- Blood glucose test-tapes
- Cardiac drugs
- Cholesterol and lipid lowering agents
- Diuretics
- Insulin
- Long term replacement hormones
- Oral contraceptives
- Oral hypoglycemics
- Prenatal vitamins
- Thyroid suppressants or replacements

These medications can be obtained through mail order. You can receive up to a 90 day supply of the above medications if your Physician has written the prescription for a 90 day supply. For more information about mail order, please visit www.medimpactdirect.com.com or call MedImpact Direct Mail Order at (855) 873-8739. A three (3) month supply of maintenance medications can also be obtained at a retail pharmacy. You will pay a three (3) month Copayment cost at either retail or mail.

Prescription Drug Prior Authorization

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before they can be covered under your benefit Plan. If the prescribed medication must have prior authorization, your pharmacist will inform you. You will need to have your Physician’s office contact MedImpact at (844) 401-2054 to request a prior authorization form. The Physician must then fax the filled out form back to MedImpact for their review. It typically takes two (2) business days to review the form if all requested information is submitted by the Physician. Otherwise, the review will take longer.
COVERED SERVICES — Continued

The Physician will be notified when the review process is completed. If your medication is not approved for Plan coverage, you will have to pay the full cost of the medication.

Outpatient Prescription Drug Exclusions

The Prescription Drug Coverage does not cover:
1. Drugs dispensed by a Hospital, nursing home, clinic, ambulatory surgical center or other institution.
2. Administration of a drug.
3. Drugs related to the treatment of non-covered services.
4. Any refill of a prescription in excess of the number specified by the Physician or for any refill dispensed after one year from the date of the Physician’s original order.
5. Over-the-counter (OTC) products, with the exception of OTC proton pump inhibitors, non-sedating antihistamines and nasal corticosteroids listed under mandatory Step Therapy and when dispensed pursuant to a Physician’s prescription.
6. Allergy and biological sera.
7. Workers’ Compensation prescriptions.
8. Experimental or Investigational drugs.
9. Drugs which are used for cosmetic purposes only (e.g., Minoxidil, topical preparations, Retin-A for wrinkles and hair replacement, Eldoquin, Eldoquin-Forte, Eldopaque, etc.).
11. A non-prescription patent or proprietary medicine, or medication not requiring a prescription.
12. Professional charges in connection with administering, injecting or dispensing of drugs.
13. Drugs or medications, dispensed or administered in an outpatient setting, including but not limited to outpatient Hospital facilities and Physician’s offices.
14. Services or supplies for which you are not charged.
15. Any drug or medication not generally considered acceptable as a form of treatment for a given diagnosis.
16. Any expense for a drug or medication incurred in excess of the Covered Expense.
17. Any prescription drug used for non–FDA approved indications (e.g., Progesterone suppositories used for PMS is not an FDA-approved indication, etc.).
18. Cosmetics, dietary supplements and health or beauty aids.
20. Appetite suppressants, diet and weight loss medications, except as required by law.
21. Scopolamine patches used for the prevention of travel sickness.
22. Any prescription vitamin (other than prenatal vitamins and folic acid), including fluoride products (except oral fluoride for children less than 6 years of age).
23. Immunization agents.
24. Any drug or medicine prescribed for the treatment of or diagnosis of infertility and for cryopreservation services.
25. Anorexients.
26. More than a 30 day supply of a medication, except when the Physician prescribes and the Plan judges it to be Medically Necessary under the circumstances. Convenience is not a Medical Necessity. Multiple Copayments will be charged for each 30 day supply of medication.
27. Replacement of lost, stolen, spilled or damaged medication.
COVERED SERVICES — Continued

28. Any drug or medication excluded from coverage under USC’s Prescription Drug Program Agreement with MedImpact.

29. Any drug or medication requiring prior authorization where prior authorization was not properly obtained.

Prescription Drug Expense Claims

Prescription drug expense claims should be submitted to MedImpact within 60 days of the fill if the Plan was not charged at the time of your medication fill. Prescription drug claim forms may be downloaded at mp.medimpact.com. Select the “Help Desk” option on the left margin toolbar. Under “Self Service Resources” you will find the “Direct Member Reimbursement” form. Each drug receipt must show the Patient’s full name, prescription number and name of medication and the charge for each item and date purchased (no reimbursement will be made for claims submitted more than 60 days after fill). Drug store cash register receipts or labels from containers are not acceptable.

Where to Send a Prescription Drug Claim

Send the completed Direct Member Reimbursement form and all your receipts to:

MedImpact Healthcare Systems, Inc. • P.O. Box 509098 • San Diego, CA 92150-9098

You can also fax your form and documents to (858)549-1569 or email them to claims@medimpact.com.

Preventive Care

The Plan covers, as Preventive Care, any recommended preventive services the Plan is required to cover under the Affordable Care Act (ACA). Eligible preventive care services include:

- Evidence-based recommended items or services of the United States Preventive Services Task Force (USPSTF) with a rating of "A" or "B";
- Immunizations recommended from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, adolescents and women.

Note: Recommended ages and populations vary for the services listed above. Refer to the charts in this section for more detailed information about eligible preventive care services. For Tier 1 and Tier 2 providers, services identified as Preventive Care are covered at 100% for the first Preventive Care service in a Calendar Year. If the same service is Medically Necessary following the first Preventive Care service in a Calendar Year, normal Plan benefit coverage at the provider Tier level (1, 2 or 3) will apply to those repeated services, except as otherwise required by the ACA.

Pre-employment physicals and work-related/travel immunizations are excluded.
## COVERED SERVICES — Continued

<table>
<thead>
<tr>
<th>TIER 1</th>
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</tr>
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<td>Non-Network Providers</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician office visit</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Preventive Care Screenings</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Outpatient Facility (if required with screening)</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

### Covered Preventive Services for Adults

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Special Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Aortic Aneurysm</strong> screening</td>
<td>A one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography who have ever smoked.</td>
<td></td>
</tr>
<tr>
<td><strong>Anemia</strong> Screening (for pregnant women)</td>
<td>Screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol Misuse</strong> screening and counseling</td>
<td>Screening and behavioral counseling interventions to reduce alcohol misuse by adults, in primary care settings.</td>
<td></td>
</tr>
<tr>
<td><strong>Bacteriuria Urinary Tract or Other Infection</strong> screening (for women)</td>
<td>Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.</td>
<td></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong> screening</td>
<td>Screening for high blood pressure in adults aged 18 and older.</td>
<td></td>
</tr>
<tr>
<td><strong>BRCA</strong> counseling and testing (for women)</td>
<td>Genetic counseling and testing for BRCA for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes.</td>
<td></td>
</tr>
<tr>
<td><strong>Breast Cancer Chemoprevention</strong> counseling (for women)</td>
<td>Counseling for women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td></td>
</tr>
<tr>
<td><strong>Breast Cancer Mammography</strong> screenings (for women)</td>
<td>Mammography screening for women with or without clinical breast examination (CBE).</td>
<td></td>
</tr>
<tr>
<td><strong>Breast Feeding</strong> interventions (for women)</td>
<td>Interventions during pregnancy and after birth to promote and support breastfeeding.</td>
<td></td>
</tr>
<tr>
<td><strong>Cervical Cancer</strong> screening (for women)</td>
<td>Screening for cervical cancer in women who have been sexually active.</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia Infection</strong> screening (for women)</td>
<td>Screening for chlamydial infection.</td>
<td></td>
</tr>
<tr>
<td><strong>Cholesterol</strong> screening</td>
<td>Screening for lipid disorders.</td>
<td></td>
</tr>
</tbody>
</table>
## Covered Preventive Services for Adults — Continued

<table>
<thead>
<tr>
<th>Covered Preventive Services for Adults</th>
<th>Special Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Colorectal Cancer</strong> screening</td>
<td>Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults. Coverage also provided if proctoscopy is used for this screening.</td>
</tr>
<tr>
<td><strong>Depression</strong> screening</td>
<td>Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
</tr>
<tr>
<td><strong>Diabetes (Type 2)</strong> screening</td>
<td>Screening for type 2 diabetes.</td>
</tr>
<tr>
<td><strong>Diet counseling</strong></td>
<td>Behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong> screening</td>
<td>Screening for Gonorrhea.</td>
</tr>
<tr>
<td><strong>Gynecological Examination</strong></td>
<td>Coverage provided for routine gynecological examinations.</td>
</tr>
<tr>
<td><strong>Hearing</strong> screening</td>
<td>Coverage provided for routine hearing screenings.</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong> screening (for women)</td>
<td>The USPSTF strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.</td>
</tr>
<tr>
<td><strong>HIV</strong> screening</td>
<td>Screening for HIV infection.</td>
</tr>
<tr>
<td><strong>Immunization Vaccines (Standard)</strong></td>
<td>Hepatitis A, Hepatitis B, Herpes Zoster (Shingles), Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella</td>
</tr>
<tr>
<td><strong>Obesity</strong> screening</td>
<td>Screening of adult patients for obesity and counseling and behavioral interventions to promote sustained weight loss for obese adults.</td>
</tr>
<tr>
<td><strong>Osteoporosis</strong> screening</td>
<td>Screening for osteoporosis.</td>
</tr>
<tr>
<td><strong>Ovarian Cancer</strong> screening (for women)</td>
<td>Coverage provided for Cancer Antigen-125 (CA-125) blood test and transvaginal ultrasound screenings for ovarian cancer when ordered or provided by a physician in accordance with the standard practice of medicine.</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
<td>Coverage provided for routine physical examinations.</td>
</tr>
<tr>
<td><strong>Prostate Cancer</strong> screening (for men)</td>
<td>Screening for prostate cancer.</td>
</tr>
<tr>
<td><strong>Rh Incompatibility screening and follow-up testing (for women)</strong></td>
<td>Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative.</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infection (STI) prevention counseling</strong></td>
<td>Behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adults at increased risk for STIs.</td>
</tr>
<tr>
<td><strong>Syphilis</strong> screening</td>
<td>Screening of persons at increased risk for syphilis infection.</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong> screening</td>
<td>Screening of all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
</tr>
<tr>
<td><strong>Tuberculin testing</strong></td>
<td>Tuberculin testing for adults, one test every 2 years.</td>
</tr>
</tbody>
</table>
### COVERED SERVICES — Continued

<table>
<thead>
<tr>
<th>Covered Preventive Services for Children</th>
<th>Special Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol and Drug Use</strong> assessments</td>
<td>Alcohol and drug use assessments for adolescents.</td>
</tr>
<tr>
<td><strong>Autism</strong> screening</td>
<td>Autism screening for children at 18 and 24 months.</td>
</tr>
<tr>
<td><strong>Behavioral</strong> assessments</td>
<td>Behavioral assessments for children of all ages.</td>
</tr>
<tr>
<td><strong>Cervical Dysplasia</strong> screening</td>
<td>Screening for cervical dysplasia in females who have been sexually active and have a cervix.</td>
</tr>
<tr>
<td><strong>Depression</strong> screening</td>
<td>Screening of children for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.</td>
</tr>
<tr>
<td><strong>Developmental</strong> screening</td>
<td>Developmental screening for children under age 3, and surveillance throughout childhood.</td>
</tr>
<tr>
<td><strong>Dyslipidemia</strong> screening</td>
<td>Dyslipidemia screening for children at higher risk of lipid disorders.</td>
</tr>
<tr>
<td><strong>Fluoride Chemoprevention</strong> supplements</td>
<td>Primary care clinicians may administer (or prescribe) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong> preventive medication</td>
<td>Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum. Coverage is only available when administered by the physician.</td>
</tr>
<tr>
<td><strong>Hearing</strong> screening</td>
<td>Screening for hearing loss in all newborn infants. Coverage also provided for routine hearing screenings for children of all ages.</td>
</tr>
<tr>
<td><strong>Height, Weight and Body Mass Index measurements</strong></td>
<td>Height, weight and body mass index measurements for children.</td>
</tr>
<tr>
<td><strong>Hematocrit or Hemoglobin</strong> screening</td>
<td>Hematocrit or hemoglobin screening for children.</td>
</tr>
<tr>
<td><strong>Hemoglobinopathies</strong> screening</td>
<td>Screening for sickle cell disease in newborns.</td>
</tr>
<tr>
<td><strong>HIV</strong> screening</td>
<td>Screening for human immunodeficiency virus (HIV).</td>
</tr>
<tr>
<td><strong>Hypothyroidism</strong> screening</td>
<td>Screening for congenital hypothyroidism (CH) in newborns.</td>
</tr>
<tr>
<td><strong>Immunizations Vaccines (Standard)</strong></td>
<td>Hepatitis A, Hepatitis B, H. Influenza type b, Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Rotavirus, and Varicella.</td>
</tr>
<tr>
<td><strong>Lead</strong> screening</td>
<td>Lead screening for children at risk of exposure.</td>
</tr>
<tr>
<td><strong>Medical History</strong></td>
<td>Medical history for all children throughout development.</td>
</tr>
<tr>
<td><strong>Obesity</strong> screening</td>
<td>Screening for children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</td>
</tr>
<tr>
<td><strong>Phenylketonuria (PKU)</strong> screening</td>
<td>Screening for phenylketonuria (PKU) in newborns.</td>
</tr>
<tr>
<td><strong>Physical (Well Child Care) Examination</strong></td>
<td>Coverage provided for routine physical (well child care) examinations.</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

<table>
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<tr>
<th>Covered Preventive Services for Children</th>
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<tr>
<td>Sexually Transmitted Infection (STI) prevention counseling</td>
<td>Behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents at increased risk for STIs.</td>
</tr>
<tr>
<td>Tuberculin testing</td>
<td>Tuberculin testing for children at higher risk of tuberculosis.</td>
</tr>
<tr>
<td>Visual Acuity screening</td>
<td>Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.</td>
</tr>
</tbody>
</table>

Reconstructive Surgery
The Plan covers reconstructive and cosmetic surgery if the surgery is needed:

- To repair an accidental injury if
  - the defect has caused severe facial disfigurement or significant functional impairment and
  - the purpose of the surgery is to improve function.
- To improve function when the treatment of an illness has resulted in severe facial disfigurement or significant functional impairment of a body part.
- As part of reconstruction following a mastectomy. Coverage includes:
  - reconstruction of the breast on which a mastectomy has been performed,
  - surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance,
  - prostheses, including one external breast prosthesis every two years (per diseased breast) and two post-mastectomy bras every six months (up to four per calendar year) and,
  - treatment of physical complications of all stages of mastectomy, including lymphedemases.

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<td>Non-Network Providers</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>Plan pays 100%</td>
<td>Plan pays 100% after Copay You pay a $300 Copay per admission</td>
</tr>
<tr>
<td>Inpatient Room and Board</td>
<td></td>
<td>Plan pays 50% of UCR after Copay You pay a $600 Copay per admission plus all charges above 50% of UCR</td>
</tr>
<tr>
<td>Outpatient Surgery Facility</td>
<td>Plan pays 100%</td>
<td>Plan pays 100% after Copay You pay a $200 Copay per admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 50% of UCR, up to a maximum of $2,700 You pay $600 Copay per admission plus remainder of charges</td>
</tr>
<tr>
<td>Physician</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
</tr>
<tr>
<td>Imaging, Tests and Lab Work</td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 50% of UCR after deductible You pay remainder of charges</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

Skilled Nursing Facility Care
Benefit are provided for Medically Necessary confinement in a Skilled Nursing Facility. These Benefits will be provided only if services are:

1. prescribed by the patient’s physician;
2. for skilled and not custodial care; and
3. for the continued treatment of an injury or illness.

Room and Board charges in excess of the facility’s established semi-private room rate are not covered.

Admission and services in connection with confinement in a Skilled Nursing Facility require prior authorization by Anthem Blue Cross as soon as possible, but not later than three (3) business days prior to admission. Failure to obtain the required prior authorization within the specified time frame may result in a reduction or denial of Benefits. A 100 day per Calendar Year limit applies to all Skilled Nursing Facility Care, regardless of cause.

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</tbody>
</table>

<table>
<thead>
<tr>
<th>Skilled Nursing Facility</th>
<th>A 100 day per person per Calendar Year limit applies to all Skilled Nursing Facility Care, regardless of cause.</th>
<th>Plan pays 50% of UCR after deductible. You pay remainder of charges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Available</td>
<td>Plan pays 100% after Copay. You pay a $300 Copay per admission.</td>
<td>Plan pays 100% after Copay. You pay a $600 Copay per admission plus all charges above 50% of UCR.</td>
</tr>
</tbody>
</table>

Coordination with USC’s Long Term Care Plan
Benefits under this Plan will be coordinated with benefits received from the USC Long Term Care Plan or any other Long Term Care Plan, so that Benefits under this Plan will be secondary to benefits provided under any Long Term Care Plan.

Smoking Cessation
Smoking Cessation Programs are limited to two (2) per person per Calendar Year. Smoking cessation medications are covered under the Prescription Drug Program.

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</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoking Cessation Program</th>
<th>Limited to two (2) courses of treatment (programs) per person per calendar year.</th>
<th>Plan pays 50% of UCR after deductible. You pay remainder of charges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of UCR after deductible. You pay remainder of charges.</td>
</tr>
</tbody>
</table>
COVERED SERVICES — Continued

Speech Therapy

Speech-language pathology services provide for the identification, assessment and treatment of speech, language and swallowing disorders in children and adults.

The Plan will provide services by a qualified provider of speech therapy services who holds the appropriate credentials in speech-language pathology; has pertinent training and experience and is certified, licensed, or otherwise regulated by the State or Federal governments. Assistants may provide services under the direction and supervision of speech language pathologist. These qualified professionals are also regulated by the State and Federal governments. Aides, athletic trainers, exercise physiologists, life skills trainers, and rehabilitation technicians do not meet the definition of a qualified practitioner regardless of the level of supervision.

Speech therapy covers Medically Necessary rehabilitative services intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness*, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and the individual stops progressing toward those goals. Rehabilitative speech-language pathology services are considered Medically Necessary when ALL of the following criteria are met:

1. The services are used in the treatment of communication and impairment or swallowing disorders resulting from illness, injury, surgery, or congenital abnormality; and
2. Based on a plan of care, the therapy sessions achieve a specific diagnosis-related goal for an individual who has a reasonable expectation of achieving measureable significant functional improvement in a reasonable and predictable period of time [i.e. Medical Necessity continues until progress is no longer being made (each three to six month period) or the individual has attained the previous level of competency]; and
3. The therapy sessions provide specific, effective, and reasonable treatment for the individual’s diagnosis and physical condition; and
4. The services are delivered by a qualified provider of speech therapy services; and
5. The services require the judgment, knowledge, and skills of a qualified provider of speech-language pathology services due to the complexity and sophistication of the therapy and the medical condition of the individual.

Speech therapy also covers Medically Necessary habilitative services that are intended to maintain, develop or improve skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality. Habilitative speech-language pathology services are Medically Necessary when ALL of the following criteria are met:

1. The therapy is intended to maintain, develop or improve speech, language, or swallowing impairment skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality; and
2. The therapy is for a condition that requires the unique knowledge, skills, and judgment of a qualified provider of speech therapy services for education and training that is part of an active skilled plan of treatment; and
3. There is an expectation that the therapy, will maintain or improve the level of functioning; and
4. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the habilitative service (not merely fluctuate); and
5. The therapy documentation objectively verifies that, at a minimum, functional status is maintained; and
6. The services are delivered by a qualified provider of speech therapy services; and
7. The services require the judgment, knowledge, and skills of a qualified provider of speech-language pathology services due to the complexity and sophisticated action of the therapy and the medical condition of the individual.

* For purposes of clarity, illness includes, but is not limited to Autism Spectrum Disorder and Rett Syndrome.
COVERED SERVICES — Continued

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</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td><strong>Speech Therapy</strong></td>
<td><strong>Speech Therapy</strong></td>
</tr>
<tr>
<td><strong>Inpatient Visits</strong></td>
<td>Plan pays 90% after deductible You pay 10% after deductible</td>
<td>Plan pays 80% after deductible You pay 20% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Visits</strong></td>
<td>Plan pays 100% after Copay You pay a $20 Copay per visit</td>
<td>Plan pays 100% after Copay You pay a $30 Copay per visit</td>
</tr>
</tbody>
</table>

**Transplants – Organ and Tissue**

Hospital, surgical and medical services for the following human transplants are covered, provided they meet all the Plan’s requirements for the specific transplant surgery, including, but not limited to, being Medically Necessary:

- Cornea Heart
- Heart/Lung
- Kidney
- Pancreas
- Pancreas/Kidney
- Simultaneous Pancreas/Kidney
- Liver
- Lung (single or double)
- Allogeneic (donor) bone marrow transplants (see donor provisions on page 49)
- Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions:
  - Acute lymphocytic or non-lymphocytic leukemia
  - Advanced Hodgkin's lymphoma
  - Advanced non-Hodgkin's lymphoma
  - Advanced neuroblastoma
  - Breast cancer
  - Multiple myeloma
  - Epithelial ovarian cancer
  - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors

The Plan covers:

- Evaluation
- Compatibility testing of prospective organ donors who are family members
- Charges for activating the donor search process with national registries
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor’s group or individual health plan
- Physician or transplant team services for transplant expenses
- Hospital inpatient and outpatient supplies and services, including:
  - Physical, speech, and occupational therapy
  - Biomedicals and immunosuppressants
COVERED SERVICES — Continued

- Home health care services and
- Home infusion services
- Follow-up care

In order to be considered as covered services, the transplant and the transplant-related services and supplies must meet all of the following requirements:

- All organ and tissue transplant services require prior authorization by Anthem Blue Cross
- The transplant must be Medically Necessary and appropriate for the Covered Person’s medical condition
- The transplant must not be Experimental or Investigational for the Covered Person’s condition

| Transplants - Organ and Tissue | TIER 1
Network Providers (see “Definitions – Tier 1”) (includes Tier 2 providers for Covered Persons < 19 years of age) | TIER 2
Anthem Blue Cross Prudent Buyer/BlueCard® Providers | TIER 3
Non-Network Providers
---|---|---|---
Room and Board | Plan pays 100% | Plan pays 100% after Copay You pay a $300 Copay per admission | Plan pays 50% of UCR after Copay You pay a $600 Copay per admission plus all charges above 50% of UCR
Physician Visits | Plan pays 90% after deductible You pay 10% after deductible | Plan pays 80% after deductible You pay 20% after deductible | Plan pays 50% of UCR after deductible You pay remainder of charges
Imaging, Tests and Lab Work | Plan pays 90% after deductible You pay 10% after deductible | Plan pays 80% after deductible You pay 20% after deductible | Plan pays 50% of UCR after deductible You pay remainder of charges

Organ Donors
The following rules apply to coverage for organ donors with respect to the transplant and transplant-related services and supplies:

- When both the recipient and the donor are covered by the Plan, each is entitled to the benefits of this Plan.
- When only the recipient is covered by the Plan, both the donor and the recipient are entitled to the benefits of this Plan, but the donor benefits are limited to those not available from any other source to which the donor may have access.
- When the donor is covered by the Plan, but the recipient is not, the Plan does not cover any services and supplies provided to the donor.
- If any organ or tissue is sold rather than donated to a recipient covered by this Plan, no expenses will be Payable.

As part of the transplant benefit, the Plan does not cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan
- Outpatient drugs, including biomedicals and immunosuppressants, except as provided above
- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness
- Harvesting or storage of bone marrow, tissue, or stem cells without the expectation of a transplant to treat an existing illness within 12 months or
COVERED SERVICES — Continued

- A pancreas transplant that is not performed in conjunction with a kidney transplant, or which is performed after the covered person has received a kidney transplant.

Transplantation Donor Benefit
When a Covered Person is the recipient, an organ or tissue donor who is not a Covered Person is also eligible for certain transplant-related services as described herein. Benefits are reduced by any amounts paid or payable by that donor's own coverage. The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The Plan’s payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed $30,000 per transplant.

Transplant Travel Expense Benefits
Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated Center of Medical Excellence or Blue Distinction Center of Specialty Care that is 75 miles or more from the recipient’s or donor’s place of residence are covered, provided the expenses are authorized by the claims administrator in advance. The Plan’s maximum payment will not exceed $10,000 per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the Center of Medical Excellence or Blue Distinction Center of Specialty Care when the designated Center of Medical Excellence or Blue Distinction Center of Specialty Care is 75 miles or more from the recipient’s or donor’s place of residence.
- Coach airfare to and from the Center of Medical Excellence or Blue Distinction Center of Specialty Care when the designated Center of Medical Excellence or Blue Distinction Center of Specialty Care is 300 miles or more from the recipient’s or donor’s residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

*Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

The Calendar Year deductible will not apply and no Copayments will be required for transplant travel expenses authorized in advance by the claims administrator. The Plan will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling HealthComp at 855-SC-PLANS (855-727-5267). All applicable receipts must be submitted to HealthComp, in order to obtain reimbursement.
COVERED SERVICES — Continued

Urgent Care Center
The Plan covers the services of an urgent care center to evaluate and treat an urgent condition. Urgent care centers are Physician-staffed facilities offering unscheduled medical services.

Urgent care services are provided for the care of a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health.

Urgent care centers are a convenient alternative to Hospital emergency rooms for conditions such as (but not limited to) minor sprains, fractures, pain, heat exhaustion and breathing difficulties that require prompt medical attention, but do not pose an immediate, serious health threat. To find a participating urgent care center, go to www.anthem.com/ca, select “Find a Doctor”, enter “TRJ” as your alpha prefix under “Search as a Member”, click on “Continue”, and select “Urgent Care” as the type of provider you are searching for, enter your zip code and click on the “Search” button.

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<tr>
<th>TIER 1</th>
<th>TIER 2</th>
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<tbody>
<tr>
<td>Network Providers</td>
<td>Anthem Blue Cross Prudent Buyer/BlueCard® Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>(see “Definitions – Tier 1”)</td>
<td>(includes Tier 2 providers for Covered Persons &lt; 19 years of age)</td>
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</tr>
<tr>
<td>Urgent Care Center</td>
<td>Not Available</td>
<td>Plan pays 50% of UCR after deductible</td>
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<td>You pay remainder of charges</td>
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Well Child Care
Also see Preventive Care section.

This coverage pays Benefits for charges incurred for physical exams and immunizations of your child. Well Child Care Benefits apply to:

1. nursery charges;
2. newborn exam and circumcision at Hospital (Tiers 1 and 2 only);
3. eligible immunizations administered by, or under the immediate direction of, a Physician;
4. periodic physical examinations by a Physician.

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<td>Well Child Care</td>
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<tr>
<td>Nursery Charges*</td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of UCR after deductible</td>
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<td>You pay remainder of charges</td>
</tr>
<tr>
<td>Newborn exam and circumcision at Hospital</td>
<td>Plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Immunizations**</td>
<td>100% (through age 25) for the immunizations listed below</td>
<td></td>
</tr>
<tr>
<td>Periodic Physical Exams</td>
<td>Plan pays 100%</td>
<td>Plan pays 50% of UCR after deductible</td>
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<td></td>
<td></td>
<td>You pay remainder of charges</td>
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</table>
COVERED SERVICES — Continued

*Note: Does not include admission to NICU. See Inpatient Benefit section for NICU coverage.

**Covered immunizations include:
- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B (limited to one each of three injections, to be completed within 12 months)
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella (MMR)
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

The 100% Well Child Care Benefits do not apply to (1) immunizations not listed above and (2) charges made by a Hospital for a service or supply furnished to an inpatient.

X-Ray / Radiology Services
The Plan covers Medically Necessary services to diagnose an illness or injury, including:
- Angiograms
- Angioplasty
- Embolization
- Discograms
- Myelograms
- Magnetic Resonance Imaging (MRI)
- PET scans

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EXCLUSIONS

The following are not covered under this Plan but nothing below will exclude, limit or restrict benefits in any way that would violate 45 CFR 92.207 to the extent it applies to the Plan and the Plan shall be automatically amended to the extent necessary to avoid any such violation.

1. Services or supplies received as a result of an accident related to employment, or sickness covered under Workers' Compensation or similar law.

2. Services or supplies (1) furnished by or for the U.S. Government or any other government, unless payment is legally required; or (2) to the extent provided under any governmental program or law under which the individual is, or could be, covered. This (2) does not apply to a state plan under Medicaid or to any law or plan when, by law, its Benefits are in excess to those of any private insurance program or other non-governmental program.

3. Services, supplies and tests that are not Medically Necessary.

4. The portion of a charge for a service or supply in excess of the Usual, Customary and Reasonable charge prevailing in the community for a service of the same nature and duration and performed by a person of similar training and experience, or for a substantially equivalent supply.

5. Services and supplies for which the Covered Person has no legal obligation to pay, or for which no charge would be made if the Covered Person was not eligible under this Plan.

6. Professional services, including nursing, speech therapy, physical therapy, occupational therapy or Home Health Care rendered by yourself, spouse, or a child, brother, sister, or parent of yourself or spouse or someone living in your home or volunteering to assist.

7. All services in connection with a home birth, including services provided by a Midwife in the home.

8. Expenses incurred as a result of illegal activity, unless the illness or injury results from domestic violence or a medical condition as determined at the discretion of the Plan Administrator.

9. Services or supplies received as a result of an act of war, riot, or insurrection.

10. Expenses incurred while on active military duty with any armed forces.

11. Expenses in connection with Cosmetic Surgery. The following are not considered to be Cosmetic Surgery:
   a. Surgery to correct the result of an accidental injury occurring while covered.
   b. Surgery to treat a condition, including a birth defect, which impairs the function of a body organ.
   c. Surgery to reconstruct a breast after a mastectomy.

12. Expenses in connection with services for the proper adjustment of a hearing aid or the purchase of a hearing aid, except as otherwise expressly provided under the Plan.

13. Expenses in connection with:
   a. exams to determine the need for (or changes of) eyeglasses or lenses of any type;
   b. eyeglasses or lenses of any type;
   c. eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring);
   d. visual training.

14. Treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches, chronic foot strain, metatarsalgia or bunions, except surgical treatment.

15. Foot care (routine), including but not limited to removal of corns, calluses or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease.

16. Orthopedic shoes, cushions, insoles, arch supports, or foot orthotics (custom molded shoe inserts).

17. Expenses for actual or attempted; (a) impregnation; or (b) fertilization; which involves either a Covered Person or a surrogate as a donor or a recipient.

18. In vitro fertilization and/or embryo transfer procedures.

EXCLUSIONS — Continued

20. Expenses in connection with infertility after diagnosis has been determined (e.g., office visits, testing, ultrasounds, and/or any related treatment to determine if procedures and/or medications for the treatment of infertility are working).

21. Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges.

22. The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests.

23. Services or supplies received before you or your dependent(s) became covered under the Plan or after coverage ended.

24. Services or supplies received during an inpatient stay which began before you or your dependent(s) became covered under the Plan to the extent permitted by law.

25. Services or supplies received after coverage for you or a covered dependent ends.

26. Services or devices or substances which are Experimental or Investigational in nature.

27. Expenses not incurred for treatment of an injury or sickness, except as specified in this booklet for preventive and wellness care (e.g., pre-employment physicals and work-related/travel immunizations).

28. Services or supplies provided without charge or where there would be no charge in the absence of medical coverage.

29. Dental care except those services or supplies shown under “Dental Coverage”.

30. Orthodontic appliances and services including braces.

31. Except as otherwise provided under the Plan or as required by law, nutritional or other services for dietary control, weight reduction or treatment of obesity.

32. Rest home or nursing home care that is custodial in nature.

33. Custodial care.

34. Private duty nursing.

35. Private room charges in excess of the rate for a standard semi-private room.

36. Telephone consultations.

37. Non-durable medical equipment and supplies. Most medical supplies of an expendable, non-reusable nature, such as incontinent pads, ace bandages, or elastic stockings are considered non-durable and are not covered items.

38. Conditions caused by atomic explosion or non-therapeutic release of nuclear energy.

39. Any confinement, treatment, service or supply not recommended by a Physician.

40. Recreational, educational, vocational, art, dance, yoga, voice or music therapy.

41. Chelation therapy and orthomolecular treatment.

42. Reversal or attempted reversal of sterilization.

43. Exercise equipment.

44. Weekend Hospital admissions, except for an Emergency.

45. Expenses incurred in connection with the donation of an internal body organ (except as provided in the Transplantation Donor Benefit provision).

46. Treatment for non-medical disorders, including services that are primarily oriented towards treating a social, developmental, learning disability or mental impairment, except as otherwise specifically covered under the Plan.

47. Recreational, educational or sleep therapy, including any related diagnostic testing, except as provided as part of an otherwise covered inpatient hospitalization.
EXCLUSIONS — Continued

48. Any service or supply provided or received primarily for religious, personal or philosophical reasons, beliefs or requirements.
49. Any service or supply for, or relating to, full body scans or similar services or supplies.
50. Massage therapy.
51. Counseling, assessment or psychological testing ordered by or for use in a court of law, unless determined to be Medically Necessary.
52. Professional training.
53. Charges for services that are not received, such as broken or missed appointments.
54. Treatment that does not meet the national standards by mental health, alcohol and drug treatment professionals.
55. Supervision of patient discharge team.
56. Administrative psychiatric services.
57. Recheck chart review.
58. L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with a diagnosis or nutritional deficiency.
59. Megavitamin orthomolecular therapy.
60. Transcendental meditation.
61. Rolfing.
62. Z therapy.
63. EST (Erhard).
64. Primal therapy.
65. Bioenergetics therapy.
66. Carbon dioxide therapy.
67. Guided imagery.
68. Confrontation therapy.
69. Narcotherapy with LSD.
70. Marathon therapy.
71. Sensitivity training.
72. Educational remediation.
73. Crystal healing treatment.
74. Inpatient treatment of “sexual addiction” except as required by law.
75. Sex therapy (without DSM-IV-TR diagnosis).
76. Hemodialysis for schizophrenia.
77. Training analysis (Tuitional, Orthodox).
78. Poetry/Art therapy.
79. Consultations with a mental health professional for purposes of adjudication of marital, child support and custody cases.
80. Inpatient substance abuse program admissions of co-dependent will not be authorized. If the spouse or a dependent of a substance abuse patient presents symptoms of a psychiatric disorder of such severity that inpatient treatment is required, such treatment should be delivered in a comprehensive, multi-modal, approved psychiatric setting. In all cases, medical/psychological necessity must be established before an individual with such symptoms can be admitted to an inpatient unit. Issues specifically related to “enabling” or other components of alcohol/drug dependency constellations will be referred to an appropriate level of care. In the majority of cases, this will be at the level of outpatient therapy or as part of the family therapy component of the primary substance abuse patient's inpatient or partial Hospital treatment.
HOW TO USE THE PLAN

Network Participating Providers
You may select Network providers from listings on one of two websites. To view providers from Keck Medicine of USC (Tier 1), please go to www.keckmedicine.org. If you would like to select a Tier 2 provider, you may access the list of providers through the Anthem Blue Cross Prudent Buyer/BlueCard® website at www.anthem.com/ca (providers within the United States) and at www.bluecardworldwide.com (outside of the United States). All Anthem Blue Cross Prudent Buyer and BlueCard® providers are recognized as Tier 2 providers except vision and dental. Please confirm with the provider selected that he/she continues to be an Anthem Blue Cross Prudent Buyer or BlueCard® provider.

Making Appointments
Select an appropriate provider and be sure to identify yourself as a USC PPO Plan participant when making the appointment. If you have selected a Tier 2 provider, please advise him/her that the USC PPO Plan is a self-insured health plan for faculty and staff of USC with access to the Anthem Blue Cross Prudent Buyer and BlueCard® network of providers. Claims should be sent to the appropriate address listed on the back of your identification card.

If Hospital admission is required, be sure to notify Anthem Blue Cross as required and identify yourself as a USC PPO Plan participant at the time of admission.

If You Or A Covered Dependent Is To Be Hospitalized
Inpatient hospitalizations, as well as selected outpatient procedures, require prior authorization. Your Physician must seek prior authorization from Anthem Blue Cross at least three (3) business days prior to admission. You must verify that services have been authorized before the procedure. At the time of admission, present your identification card to the admissions clerk. Prior to admission or at the time of admission, the Hospital may confirm your Hospital Benefits by contacting HealthComp. You may be required to pay your Hospital Copayment at the time of admission or at the time of discharge. Most Hospitals will submit claims directly to the address found on the front of your identification card.

Claim Payments
All claim payments should be assigned to the provider whenever possible. The assignment ensures that the provider will receive a copy of the Explanation of Benefits to facilitate correct billing of any Copayments, Coinsurance and other non-covered amounts that may be your financial responsibility.

Patient Responsibility For Payment
A Non-Network Provider may agree to reduce billed charges to the UCR allowed amount as determined by the Plan’s claims administrator, HealthComp. If, however, any Network or Non-Network Provider waives any obligation to pay amounts not covered by the Plan (e.g., Coinsurance or Copayments up to 100% of the allowed amount), the Plan will not pay ANY Benefit for any related Covered Service from that provider. See Exclusions, page 53, #5. The Plan’s claims administrator, HealthComp, has the authority to audit any provider who bills the Plan and to require evidence that Coinsurance and Copayments have been paid by Covered Person. HealthComp may audit provider before paying claims for the Covered Services related to such Coinsurance or Copayment amounts and not pay provider until provider can demonstrate that such amounts have been received. HealthComp may audit provider after payment and require reimbursement from provider or offset future payments to provider who does not collect Copayments or Coinsurance.
HOW TO USE THE PLAN — Continued

How To Present A Claim

In most cases, the provider of service will file your claims directly with the Plan. All medical claims should be sent to:

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<tr>
<th>PROVIDERS SUBMITTING CLAIMS</th>
<th>COVERED PERSONS SUBMITTING CLAIMS</th>
</tr>
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<tbody>
<tr>
<td>For Services In California</td>
<td>For Services Outside of California</td>
</tr>
<tr>
<td>Prudent Buyer Plan P. O. Box 60007 Los Angeles, CA 90060-0007</td>
<td>Submit to your local Blue Cross and / or Blue Shield plan in the state where the service is rendered. To ensure prompt claims processing, include the 3 digit alpha prefix (TRJ) that precedes the patient’s ID number.</td>
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</tbody>
</table>

If the provider will not bill on your behalf you will have to submit your claims for payment. Be certain to obtain an itemized statement from the provider. A “Medical Claim Form” must accompany all claims you submit. A claim form can be obtained from the HealthComp website at www.healthcomp.com.

When you submit a claim, please complete the following steps:

Complete the “Patient and Employee Information” section of the claim form. A separate form will be required for each accident or illness of each family member. Also, a separate form will be required for each provider who is billing for medical services. To avoid delay, be sure to answer each question completely.

Staple (do not use paper clip) the fee bill prepared by the provider to the claim form or have the provider complete the “Physician or Supplier Information” section of the claim form. Please be certain to submit the original bills and retain copies for your files. If you choose to attach a fee bill, you must confirm that all of the information needed for the “Physician/Supplier Information” section is contained on the fee bill. Bills and receipts should be itemized and include:

- Patient’s full name
- Date(s) the service was rendered or purchase was made
- Diagnoses (nature of the sickness or illness)
- Type of service or supply furnished
- Service provider name, address and tax ID number
- Itemized charges
- Copies of the explanation of benefits for any payments or denials made by any other insurance payor
- Receipts, if you have already paid for the services

If information is missing from the fee bill, you will need to obtain it from the provider and include it on the claim form. If HealthComp needs more information from you, please reply promptly to avoid a delay in processing your claim.

When You Have A Claim

A claim should be submitted within 30 days after treatment or as soon as reasonably possible. No claims for expenses submitted more than one year from the date of service will be considered for payment.

Refer to How to Submit a Claim (above) for the claims submission address(es).
HOW TO USE THE PLAN — Continued

If any Benefits are payable to your estate or to a person not competent to give valid release, the Plan may pay up to $1,000 to any person related to you or to your beneficiary whom it deems to be entitled; USC will then be discharged to the extent of the payment due.

What to Expect

Each time a bill is submitted to HealthComp by either the patient or the provider of services, an explanation of benefits (EOB) is sent to the insured. If payment is assigned to the provider of service, then an EOB is sent to the provider as well. **If you obtain care from a USC Network Provider (Tier 1 or 2), please wait for the EOB before you pay the provider.** You and the Plan are entitled to special discounts which will be indicated on the EOB.

The EOB describes how HealthComp adjudicated the claim. It indicates the names of the insured, patient, and provider as well as the details of the charge and the payment calculation. It will list the billed amount, allowed amount (either contract rate or UCR), Copay amount, % Benefit (percentage paid by the Plan), Plan payment and patient responsibility (Copayment and Coinsurance combined).

The EOB will indicate to whom payment was made. If the bill indicates that the patient has assigned Benefits, then the check will be issued to the provider.

Sometimes you will receive two or more bills for the same transaction from different providers. This is particularly true for lab and x-ray services. For outpatient lab and X-ray charges, you will often be charged both a facility charge (a bill from the Hospital, imaging center or lab where the test/X-ray was performed) and a bill from the Physician who read the X-ray or interpreted the lab results. When you have surgery, there will often be a bill from the facility, the surgeon, the assistant surgeon (if one was present) and the anesthesiologist. You can expect to receive EOBs for each one of the bills.

If you have any questions after you receive your EOB or if you do not receive the EOB in a timely fashion, you may call the customer service representative at HealthComp at (855) SC-PLANS (855-727-5267).
Coordination Of Benefits

Our Plan contains the provisions for coordinating with other similar health plans when Covered Persons are covered by more than one plan. This allows combining coverage to benefit the Covered Person, but not to permit reimbursements to be made which would exceed the actual Eligible Expenses incurred. For instance, if you are covered under two plans because your spouse lists you as a dependent under a group plan where he/she is employed, this will apply. If both, husband and wife are covered under the USC Plan as employees, each may be considered an eligible dependent of the other except that both may not enroll in the USC PPO Plan and be covered as employees and dependents at the same time.

When a claim is made, the primary plan pays its benefits without regard to any other plan. A secondary plan adjusts its benefits to pay the balance of the remaining Eligible Expenses, if any, up to its maximum responsibility as set forth in this booklet. No plan pays more than it would without the coordination provision.

Example: Primary Plan (other than the USC PPO Plan) has a maximum allowable charge of $1,000 with 20% coinsurance for the service in question, so the Primary Plan pays $800 for that service, leaving the covered person with a liability of $200. The USC PPO Plan is the secondary plan for that service and the maximum allowable care for that service under the USC PPO Plan is also $1,000. Therefore, for this service the USC PPO Plan will reimburse the covered person in the amount of $200.

All applicable Copayments and Coinsurance will remain the Covered Person’s responsibility.

When the Benefit payable under the primary plan is reduced or denied as a result of the Covered Person’s failure to comply with the provisions of the primary plan (e.g. prior authorization, second surgical opinion, etc.) the USC PPO Plan will not consider such non-payments or penalties to be Eligible Expenses and will not cover such penalties or non-payments by the primary plan.

Example: Primary plan requires prior authorization for Medically Necessary outpatient surgery. Patient fails to obtain prior authorization. Primary plan would have paid 80% of a contracted rate of $1,000 or $800 with prior authorization. Without it, primary plan pays only 50% of the contracted rate or $500. The 30% or $300 difference is a penalty assessed by the primary plan for failure to comply with its requirements. Provider is also a participating provider under the USC PPO Plan with the same contract rate. USC PPO Plan will subtract any penalty from the remaining balance after primary plan payment, and pay up to its contractual amount.

$1,000 Contract rate of primary plan and USC PPO
– $500 Only 50% of contract rate (penalty for non authorization)
$500 Remaining balance
– $300 Penalty assessed by primary plan (paid by the patient)
$200 maximum that USC PPO pays as secondary plan

Any health plan that does not contain a Coordination of Benefits provision will be considered primary. When another plan covering you and/or your dependents contains a coordination of Benefits provision, the order of payments will be as follows:

1. the plan covering the patient directly as an employee, rather than as an employee's dependent, is primary and the other plan is secondary;
2. if a child is covered under both parents' plans and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year is primary; but if both parents have the same birthday, the plan that covered the parent longer is primary;
3. if a child is covered under both parents' plans and the parents are separated or divorced, their plans pay in the following order:
   a. if a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;
   b. the plan of the parent with custody of the child;
GENERAL INFORMATION — Continued

c. the plan of the stepparent married to the parent with custody of the child;
d. the plan of the parent not having custody of the child;
e. if there is joint custody and no court decree establishing financial responsibility, the birthday rule is used.

4. the plan covering the patient as an active employee or as that employee's dependent is primary and the plan which covers the patient as a laid off or retired employee or as that employee's dependent is secondary;

5. if (1), (2), (3) or (4) do not apply, the plan covering the patient longest is primary.

The Benefit of a plan which covers a person as an employee (or a dependent of an employee) will be determined before those of a plan which covers that person as a former employee (or a dependent of such person). Furthermore, to the extent a person is legally permitted under COBRA to maintain coverage under this Plan and another group health plan, the Benefits of that other group health plan will be determined before those of this Plan.

Special Coordination of Benefits Rule for Non-Group Insurance and Travel Health Insurance

Where a Covered Person is covered under any form of non-group health insurance or travel health insurance (group or non-group), the following special coordination of benefits rule applies: This Plan is always secondary to any form of non-group health insurance and/or travel health insurance (group or non-group).

Modification of Benefits

Under certain conditions, Benefits payable under the Plan may be modified by the Plan Administrator to provide alternative treatment for a Covered Person’s catastrophic (or which, in the Plan Administrator’s judgment, could become catastrophic) sickness or injury. Benefit modification will be determined exclusively by the Plan Administrator in its discretion. The Plan Administrator shall have the right to review the patient’s medical needs and determine which services, supplies and providers are available under the modification of Benefits, taking into consideration such factors as the Plan Administrator deems appropriate, including, but not limited to, the cost-effectiveness of any Benefit modification. The Plan Administrator shall determine the Benefit coverage under which the alternative treatment shall be considered payable and the duration of the Benefit modification. Alternative treatment does not include services and supplies which the Plan Administrator determines to be experimental or investigational or otherwise inappropriate.

Subrogation

The following provision shall apply to all Benefits provided under any section of this Plan:

A Covered Person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of Benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan’s first lien supersedes any right that the Covered Person may have to be “made whole”. In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys’ fees or costs. Additionally, the Plan’s right of first Reimbursement will not be reduced for any reason, including attorneys’ fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving Benefits under the Plan, the Covered Person agrees that acceptance of Benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in the Covered Person’s name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person’s rights to Recovery when this provision applies;

3. Within 10 business days, reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other Benefits paid for the injuries or illness under the Plan and expenses (including attorneys’ fees and costs of suit, regardless of an action’s outcome) incurred by the Plan in collecting this amount (without reduction for attorneys’ fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan’s written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

6. When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future Benefits for other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan’s rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. However, failure or refusal on the Covered Person’s part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan’s right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, out of any Recovery without reduction for attorneys’ fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

“Covered Person” means anyone covered under the Plan, including minor Dependents.

“Another Party” shall mean any individual or organization, other than the Plan, who is liable or legally responsible (or who is alleged or claimed to be liable or legally responsible) to pay expenses, compensation or damages in connection with a Covered Person’s injuries or illness.

“Another Party” shall include the party or parties who caused the injuries or illness (or are alleged or claimed to have caused the injuries or illness); the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person’s own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or organization that is liable or legally responsible (or is alleged or claimed to be liable or legally responsible) for payment in connection with the injuries or illness.

“Recovery” shall mean the specific fund of any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.
“Reimbursement” shall mean repayment from the Recovery to the Plan for medical or other Benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this Benefit amount.

“Subrogation” shall mean the Plan’s right to pursue the Covered Person’s claims for medical or other charges paid by the Plan against Another Party.

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of Benefits and as a condition to any payment of future Benefits for other illnesses or injuries. Additionally, the Covered Person’s attorney must recognize and consent to the fact that the Plan precludes the operation of the “made-whole” and “common fund” doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person’s attorneys’ fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person’s attorneys’ fees and costs. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed out of the Recovery.

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor’s representative has access or control of the Recovery.

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Covered Person and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the illness or injury, which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are incurred related to an illness or injury for which a Recovery has been made. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

Medicare Program

Beneficiaries who are covered under Medicare will be subject to coordination of Benefits with the USC PPO Plan assuming primary payor status to the extent required by applicable law. Medicare assuming secondary payor status may pay the balance of the remaining Eligible Expenses, if any, less payments from the Plan. All
applicable Copayments and Coinsurance will remain the Covered Person’s responsibility. To the extent Medicare is the primary payor under applicable law, the Plan will be the secondary payor. For example, to the extent permitted by law the USC PPO Plan (the Plan) will be secondary to Medicare for a Covered Person who has been eligible for Medicare for 30 months due to End Stage Renal Disease (ESRD) or for a disabled employee who is not actively working and is eligible for Medicare due to that disability. In such cases, the USC PPO Plan will pay on a secondary basis to Medicare, even if the Medicare-eligible Covered Person has not enrolled in Medicare. Therefore, to prevent a gap in coverage, it is very important for a Medicare-eligible Covered Person, for whom the Plan can legally be a secondary payor to Medicare, to be covered by Medicare as soon as he or she is eligible or, if later, by the first day of the seventh month of any available Medicare Part B Special Enrollment Period immediately following the Covered Person’s termination of employment at USC. Contact Medicare for more information about Part B Special Enrollment Periods.

Termination of Coverage

The coverage for yourself and your covered dependents will terminate if you cease to be an eligible employee or if the Plan is discontinued or if you or your covered dependent commits any fraudulent or illegal act in connection with participation in the Plan. The coverage for which contributions are required, if any, will terminate if you stop making contributions.

A dependent's coverage will terminate when he/she is no longer an eligible dependent. However, if you or any of your covered dependents cease to be eligible, you must initiate your deletion request through the Workday Employee Self Service system in order to remove that person from your coverage.

In the event of termination of employment, your coverage will terminate the last day of the month in which you terminate. In the event of termination for cause (fraud or illegal activity), subject to the ACA, termination will be retroactive to the date participation in the Plan commenced and the Plan will be entitled to full refund of all claims paid on behalf all Covered Persons.
1. Q. What is the difference between a Copayment and Coinsurance?
   A. A Copayment is a fixed dollar amount, like $200.00 for an Emergency Room visit. Coinsurance is a percentage of the cost of the visit, such as a 10% co-insurance for an x-ray or lab test done at the Keck Hospital of USC.

2. Q. I was treated by a provider who agreed to accept “whatever my insurance covers” as payment in full and not bill me for my Coinsurance. Why is the Plan refusing to pay for my treatment?
   A. Under the terms of the USC PPO Plan you have a legal obligation to pay your Coinsurance or Copayment (with Non-Network Providers you must pay at least 50% of the allowed amount) as determined by HealthComp (This amount appears on the Explanation of Benefits or EOB you receive from HealthComp). If you do not pay the provider what you are obligated to pay under the Plan, the Plan is released from its obligation to pay (See Exclusions, #5 and #28). This means that if a provider releases you from your obligation to pay the applicable Copayment and/or Coinsurance amounts, the Plan will not pay any amount for any Covered Service from that provider related to those waived Copayment or Coinsurance amounts.

3. Q. Where can I go to get 100% coverage for medical services?
   A. There is no provider or facility that the Plan automatically or necessarily covers at 100%. The Keck Medicine physicians and facilities generally offer a lower patient responsibility under the Plan in comparison to other contracted and non-contracted providers.

4. Q. If I go to a Keck Medicine physician and lab specimen is collected at USC, why do I have a coinsurance of 20% or 50% instead of 10%?
   A. If the lab specimen is sent outside a contracted Keck Medicine lab, benefit levels will be determined by the Tier level of the laboratory performing the service and not the Tier level of the physician requesting the lab work.

5. Q. How can I find out if my doctor has already billed my insurance for a service I had done?
   A. You can register on HealthComp’s website at www.healthcomp.com as a “Member” and you will be able to view all of your claims received and processed by HealthComp.

6. Q. I received my prescription ID card. When will my medical ID card be mailed?
   A. The ID card you receive from HealthComp is a combination (combo) card. This means that you are to show this card when receiving medical, pharmacy, and mental health services.

7. Q. Do I have to choose a Primary Care Physician when I choose this Plan?
   A. No. The USC PPO Plan does not mandate or permit you to choose a primary care physician. This PPO plan gives you the flexibility to determine which physician you see. However, it is a good idea to see a particular physician who can oversee your general medical care and who will be able to guide you to appropriate specialists when needed, but this is not mandatory and such physician would not be a “primary care physician” for purposes of the Plan.

8. Q. How can I determine who is a Tier 2 provider?
   A. The Anthem Blue Cross Prudent Buyer and/or BlueCard® program participating physicians, hospitals and ancillary (e.g., physical therapy, laboratory) providers are considered Tier 2 providers. You can go on-line to www.anthem.com/ca to search for Anthem Blue Cross Prudent Buyer providers in California and BlueCard® providers in other parts of the United States. For Tier 2 providers outside of the United States, search for BlueCard Worldwide® providers at www.bluecardworldwide.com. Always search these web sites as a “Visitor” and not a “Member”. You can request the search to fit your needs (e.g., a provider in a specific specialty in a particular city name or zip code area).
Q & A — Continued

9. Q. I’m leaving the country and want to verify whether or not BlueCard Worldwide® providers (Tier 2) are available in the area I will be staying. Where can I look up providers or call for assistance?
   A. You can search for providers on-line before you leave at www.bluecardworldwide.com or you can also contact the BlueCard Worldwide Service Center at (800) 810-2583 for assistance in locating providers. If you are out of the country and need assistance finding a provider, you can call the BlueCard Worldwide Service Center collect at (804) 673-1177.

10. Q. Are all Anthem Blue Cross Prudent Buyer and BlueCard® providers considered Network providers?
    A. No. The Plan will use MedImpact as your prescription drug provider.

11. Q. Will provider directories be printed and distributed listing Tier 1 and Tier 2 providers?
    A. You can look up Keck Medicine of USC Tier 1 providers through the Plan’s website at www.keckmedicine.org, Tier 2 providers at www.anthem.com/ca for Anthem Blue Cross Prudent Buyer providers in California and BlueCard® providers in other parts of the United States, and www.bluecardworldwide.com for BlueCard Worldwide® providers outside of the United States.

12. Q. Do I have to submit any kind of verification for my eligible dependents who are 19 years or older?
    A. No. Your dependent child(ren) are eligible for coverage through age 25.
NOTICE OF NON-DISCRIMINATION

USC PPO Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. USC PPO Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

USC PPO Plan:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact Prateek Bhatia, Ph.D.

If you believe that USC PPO Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Prateek Bhatia, Ph.D., Assistant Vice President, 1150 S. Olive St., Suite 2150, Los Angeles, CA 90015, telephone: 213-740-0035, fax: 213-740-0265, email: pabhatia@usc.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Prateek Bhatia, Ph.D., Assistant Vice President, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


If you speak Spanish, Chinese, Vietnamese, Tagalog, Korean, Armenian, Persian-Farsi, Russian, Japanese, Arabic, Punjabi, Cambodian, Hmong, Hindi, or Thai, language assistance services, free of charge, are available to you. Call 1-213-740-0035.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-213-740-0035.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-213-740-0035.


NOTICE OF NON-DISCRIMINATION – Continued

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-213-740-0035 번으로 전화해 주십시오.

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Notes