

# ERISA Summary Plan Description

## Introduction

This document presents basic information provided by USC, which is the ERISA Plan Administrator of your plans, concerning the medical, dental, vision, life insurance and accidental death and dismemberment coverage options maintained by USC and any severance benefits payable for layoffs from USC, and your rights as a plan participant, to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For complete details on specific items such as eligibility, benefit coverage, definitions, loss or reduction of benefits, coordination of benefits, exclusions and limitations, and the like, please refer to the applicable description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage issued to you by USC, an insurance company, or an HMO. or in the case of severance benefits, the Severance Pay Plan document, and any related Exhibits. Separate summary plan descriptions are available for the retirement plans at [employees.usc.edu/benefits-perks/retirement-benefits/](https://employees.usc.edu/benefits-perks/retirement-benefits/).

This document, the complete contents of the Employee Gateway ([employees.usc.edu](https://employees.usc.edu)), the separate benefit booklets and plan documents together constitute the Summary Plan Description for the medical, dental, vision, health care FSA, life insurance and accidental death and dismemberment coverage options maintained by USC and the severance benefits available from USC. and is intended to comply with the disclosure requirements set forth under ERISA. A complete list of participating employers may be obtained upon written request from the benefits office.

Please read this document carefully. You may wish to print a copy for future reference. You may also obtain a copy at no charge by contacting the HR Service Center at 213-821 -8100 or [uschr@usc.edu](mailto:uschr@usc.edu).

**Por favor lea cuidadosamente este documento. Es posible que desee imprimir una copia para referencia futura. Tambien puede obtener una copia sin cargo comunicandose con el Centro de Servicios de Recursos Humanos al 213-821-8100 o [uschr@usc.edu](mailto:uschr@usc.edu).**

**Important information about your plans:**

Plan name and number	Plan sponsor, administrator and identification number	Agent for service of legal service	Plan type, administration, and plan year end	HMOs, insurers, and claims administrators		
University of Southern California Group Health and Dental Plan (PN520)	University of Southern California 851 Downey Way, Suite 101B Los Angeles, CA 90089-1057 EIN 95-1642394 (213)740-0035	University of Southern California 3551 Trousdale Pkwy Room 352 Los Angeles, CA 90089-5013 (213)740-7922	Medical, Self-Insured December 31	HealthComp P.O.Box 45018 Fresno, CA 93718-5018	Anthem Blue Cross 21215 Burbank Blvd. Woodland Hills, CA91367	Navitus Health Solutions 361 Integrity Drive Madison, WI 53717
			Dental, Self-Insured December 31	Delta Dental 560 Mission St., Suite 1300 San Francisco, CA 94105		
			Vision, Self-Insured December 31	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670		
University of Southern California Group Health and Dental Plan (PN521)	University of Southern California 851 Downey Way, Suite 101B Los Angeles, CA 90089-1057 EIN 95-1642394 (213)740-0035	University of Southern California 3551 Trousdale Pkwy Room 352 Los Angeles, CA 90089-5013 (213)740-7922	Medical, Insured December31	Anthem Blue Cross 21215 Burbank Blvd. Woodland Hills, CA 91367	Kaiser Permanente Claims Administration- SCAL P.O. Box 7004 Oakland, CA 90242-7004	
			Dental, Insured December31	United Concordia 21700 Oxnard Street, Suite 500 Woodland Hills, CA 91367		
	University of Southern California CUB 200 Los Angeles, CA 90089-1057 EIN 95-1642394 (213)740-0035	University of Southern California 3551 Trousdale Pkwy Room 352 Los Angeles, CA 90089-5013 (213)740-7922	Life, Insured. December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		
			Accidental Death and Dismemberment, Insured December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		
			Voluntary Accident Insurance, Insured December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		
			Voluntary Critical Illness Insurance, Insured December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		
			Voluntary Hospital indemnity Insurance, Insured December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		
			Legal Plan, Insured December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		
			Identity & Fraud Protection, Insured December 31	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100		

			Health Care FSA, Self-insured December 31	HealthEquity, Inc. 15 West Scenic Pointe Drive, Suite 100 Draper, UT 84020		
			Dependent Care FSA, Self-Insured December 31	HealthEquity, Inc. 15 West Scenic Pointe Drive, Suite 100 Draper, UT 84020		
John Hancock Long-Term Care			Long-term care (closed to new participants effective 12/31/11) December 31	John Hancock PO Box 111 Boston, MA 02117		
Genworth Long-Term Care	University of Southern California CUB 200 Los Angeles, CA 90089-0704 EIN 95-1642394 (213)740-7922	University of Southern California 3551 Trousdale Pkwy Room 352 Los Angeles, CA 90089-5013 (213)740-7922	Long-term care December 31	Genworth Life Insurance Company Group Processing Center- USC P.O.Box 64010 St. Paul, MN 55164-0010		
University of Southern California Severance Pay Plan (PN525)	University of Southern California CUB 200 Los Angeles, CA 90089-0704 EIN 95-1642394 (213)740-7922	University of Southern California 3551 Trousdale Pkwy Room 352 Los Angeles, CA 90089-5013 (213)740-7922	Severance Pay Plan, Self-Insured June 30	University of Southern California		

The vendors listed above for coverages with self-insured status provide certain administrative services for the self-insured coverages. These self-insured coverages are funded by USC from its general assets. These vendors provide claims payment and other administrative services under an administrative services contract with the university, but they do not assume any financial risk or obligation with respect to claims or benefits under the coverages. The vendors listed above for coverages with a fully-insured status provide benefits under one or more insurance policies or contracts issued to the university. These vendors are solely responsible for financing and providing the benefits under the insurance policies and contracts. The university has no liability for any benefits due, or alleged to be due, under any such insurance policies or contracts.

### Plan administration

The administration of the plans shall be under the supervision of the Plan Administrator listed above. To the fullest extent permitted by law, the Plan Administrator and any delegate of the Plan Administrator (including, but not limited to, a vendor providing claims administration services for a self-insured plan), shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plans, including but not limited to the determination of whether or not a benefit is payable, and if so, in what amount, and decisions on appeals, and the Plan Administrator (and any such delegate) shall have the discretion to determine all matters relating to the interpretation and operation of the plans. Any determination by the Plan Administrator or its delegate shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

Any insurance carrier, as a claim fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy.

Any and all of the insurance carrier's decisions with respect to the group insurance policy shall be conclusive and binding on all persons.

### Sources of plan contributions

Contributions for coverage under the plans may be made solely by USC or by the participating employees, as determined by USC in its sole discretion. Some coverages require joint contributions from USC and the participating employees, as determined by USC in its sole discretion.

### Amendment and termination of the plans

The plan sponsor has established the plan with the bona fide intention and expectation that they will be continued indefinitely,

but the plan sponsor shall not have any obligation whatsoever to maintain the plan for any given length of time, and the plan sponsor may at anytime amend or terminate the plans, in whole or in part, with respect to any or all its participants and/or beneficiaries. Any such amendment or termination shall be affected by a written instrument signed or approved by an officer of the plan sponsor no vested rights of any nature are provided under the plans.

### **Support order procedures**

Upon request, copies of the university's procedures for Qualified Medical Child Support Orders (QMCSOs) may be obtained from the plan administrator free of charge.

### **Statement of ERISA Rights**

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

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for rules governing your COBRA continuation coverage rights.

#### **Prudent Actions by Plan Fiduciaries**

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

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

#### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy

of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

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

## **CLAIMS AND APPEAL PROCEDURES**

### **I. Claims and appeal procedures- medical, dental and vision**

The following sections set forth the claims and appeals procedures that apply to the various plans and, in some cases, benefits under the plans in the event that a claim for benefits under the plan is denied. Nothing in these procedures constitutes any waiver of the attorney-client or work-product privileges and those privileges are fully reserved. Prior to seeking judicial relief, a participant or beneficiary must fully exhaust his or her appeals under the Plan.

For claims related to benefits provided through the Anthem Blue Cross HMO Plans, Kaiser Traditional HMO Plan and United Concordia Dental Plan please refer to the evidence of coverage provided by the carriers for claims and appeals information.

#### **Claims for benefits**

A claim for benefits is a request for a plan benefit or benefits, made by a covered employee/dependent or his or her authorized representative that complies with the plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the plan.

#### **General Claims and Appeals Information**

##### **Notification of claims decision: Urgent care claims**

The Plan Administrator (or the applicable claims administrator, insurer or HMO, hereafter the "delegate") will notify the claimant of the plan's claims decision as soon as possible, but not later than 72 hours after receipt of the claim by the plan. However, if the claimant (or the claimant's representative) does not provide sufficient information to decide the claim, the Plan Administrator (or the delegate) will notify the claimant of the specific information necessary to complete the claim not later than 24 hours after receipt of the claim by the plan. The claimant will be afforded a reasonable amount of time under the circumstances (not less than 48 hours) to provide the specified information. The Plan Administrator (or the delegate) will notify the claimant of the plan's claims decision as soon as possible, but in no case later than 48 hours after the earlier of the plan's receipt of the specified information or the end of the period afforded to the claimant to provide the specified information.

If the plan has approved a benefit or service to be provided for a specified or indefinite time period, any reduction or termination of the benefit or service (other than by plan amendment or termination) before the end of that period constitutes an adverse claims decision. To the extent that this decision denies an urgent care claim, the Plan Administrator (or the delegate) will provide notice of the adverse claims decision sufficiently in advance of the reduction or termination to allow the claimant (or the claimant's representative) to appeal and obtain a determination on appeal before the benefit is reduced or terminated. In addition, any urgent care claim requesting an extension of a course of treatment beyond the initially prescribed time period or number of treatments must be decided within not more than 24 hours of the request, provided the claim is made at least 24 hours before the expiration of the initially prescribed period or number of treatment.

## **Notification of claims decision: Non-urgent care claims**

### *Concurrent care*

If the plan has approved a benefit or service to be provided for a specified or indefinite time period, any reduction or termination of the benefit or service (other than by plan amendment or termination) before the end of that period constitutes an adverse claims decision.

### *Pre-service claims*

A “pre-service claim” is any request for an approval of a benefit where the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving the health care (e.g., pre-authorization).

The Plan Administrator (or the delegate) will notify the claimant of the plan’s benefit determination within a reasonable time period, but not later than 15 days after receipt of the claim by the plan. This period may be extended by the plan for up to 15 days, provided that the extension is necessary due to matters beyond the control of the plan and the Plan Administrator (or the delegate) notifies the claimant in writing or electronically prior to the expiration of the initial 15 -day period. The notice to the claimant will state the reason for the extension and the date by which the plan expects to provide a decision. If the extension is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant then has 45 days from receipt of the notice within which to provide the specified information.

### *Post-service claims*

“Post-service claims” are any group health plan claims that are not pre-service claims.

The Plan Administrator (or the delegate) will notify the claimant of the plan’s benefit determination within a reasonable time period, but not later than 30 days after receipt of the claim by the plan. This period may be extended by the plan for up to 15 days, provided that the extension is necessary due to matters beyond the control of the plan and the Plan Administrator (or the delegate) notifies the claimant in writing or electronically prior to the expiration of the initial 30-day period. The notice to the claimant will state the reason for the extension and the date by which the plan expects to provide a decision. If the extension is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant then has 45 days from receipt of the notice within which to provide the specified information.

## **Manner and content of notification of claims decision**

The Plan Administrator (or the delegate) will provide claimants with a written or electronic notification of the plan’s claims decision. If the claim is wholly or partially denied, or if a rescission of coverage occurs (each an “Adverse Benefit Determination”), the Plan Administrator will furnish the claimant with a written notice of the Adverse Benefit Determination. The written notification will include:

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the decision is based;
- A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why that material or information is necessary;
- A description of the plan’s review procedures and the time limits applicable to those procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision on review,
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol or (2) a statement that a copy of the rule, guideline, or protocol will be provided free of charge to the claimant upon request;
- If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or (2) a statement that an explanation will be provided free of charge to the claimant upon request; and
- For adverse claims decision involving an urgent care claim, a description of the expedited review process applicable to those claims.

In the case of an adverse claims decision involving an urgent care claim, the information may be provided to the claimant orally within the time frame prescribed for urgent care claims, provided that a written or electronic notification is furnished to the claimant not later than three days after the oral notification.

In the case of an Adverse Benefit Determination, the Plan must:

- Ensure that any notice of Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and provide notice of the opportunity to request (1) the diagnosis code and its corresponding meaning and (2) the treatment code and its corresponding meaning.
- Ensure that the reason or reasons for the Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim.
- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

### **Appeal of adverse claims decisions**

Upon receipt of an adverse claims decision, the claimant has up to 180 days to file an appeal with the Plan Administrator (or the delegate). The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. The appeal will be reviewed by an appropriate named fiduciary (the "reviewer") of the plan who is neither the party who made the adverse claims decision that is the subject of the appeal, nor the subordinate of that party. The decision on appeal of an adverse claims decision will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether that information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse claims decision.

In deciding the appeal of any adverse claims decision involving a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the reviewer will consult with a health care professional, who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be independent of any health care professional who participated in the initial adverse claims decision. In addition, the plan will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse claims decision, without regard to whether the advice was relied upon in making the claims decision.

Appeals of adverse claims decisions involving urgent care claims are subject to an expedited review process. The request for appeal may be submitted orally or in writing by the claimant or the claimant's representative. All necessary information, including the plan's claims decision on review of an urgent care claim, will be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

### **Notification of adverse claims decision on review**

The Plan Administrator (or the delegate) will notify the claimant of the plan's claims decision on review within a reasonable time period appropriate to the circumstances.

#### *Urgent care claims*

For urgent care claims, the Plan Administrator (or the delegate) will notify the claimant of the plan's claims decision on review as soon as possible, but not later than 72 hours after receipt of the claimant's request for review of an adverse claims decision.

### *Pre-service non-urgent care claims*

For pre-service claims, the Plan Administrator (or the delegate) will notify the claimant of the plan's claims decision on review not later than 30 days after receipt by the plan of the claimant's request for review of an adverse claims decision.

### *Post-service non-urgent care claims*

For post-service plan claims, the Plan Administrator (or the delegate) will notify the claimant of the plan's claims decision on review not later than 60 days after receipt by the plan of the claimant's request for review of an adverse claims decision.

### **Manner of content of notification of adverse claims decision on review**

The Plan Administrator (or the delegate) will provide claimants with written or electronic notification of a plan's benefit determination on review. In the case of an adverse claims decision, the notification must set forth:

The specific reasons for the adverse decision;

- Reference to the specific plan provisions on which the claims decision is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits, without regard to whether those records were considered or relied upon in making the adverse claims decision on review, including any reports, and the identifies of any experts whose advice was obtained;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about those procedures;
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision on review;
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol or (2) a statement that a copy of the rule, guideline, or protocol will be provided free of charge to the claimant upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (2) a statement that the explanation will be provided free of charge to the claimant upon request.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what maybe available is to contact your local Department of Labor Office or your state insurance regulatory agency."

In the case of an Adverse Benefit Determination, the Plan must:

- Ensure that any notice of Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and provide notice of the opportunity to request (1) the diagnosis code and its corresponding meaning and (2) the treatment code and its corresponding meaning.
- Ensure that the reason or reasons for the Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim.
- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.



## External review

In the case of an Adverse Benefit Determination, you may be entitled to request an independent, external review of our decision. If your situation is urgent, you may be entitled to an expedited external review.

More information about your external review rights, including the timeframe and procedure for requesting an external review, will be provided to you in the Notice of Final Internal Adverse Benefit Determination.

## Appeals for the Anthem Self-Funded Plan

The claims and appeals procedure Anthem will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations (as described immediately above in the General Appeals and Claims Information).

### **For purposes of these Anthem Self-Funded Plan Appeal provisions, “claim for benefits” means a request for benefits under the plan.**

The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.
- If your claim is denied or if your coverage is rescinded:
- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

## **Notice of Adverse Benefit Determination**

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

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

For claims involving urgent/concurrent care:

- Anthem’s notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

## **Appeals**

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim.

Anthem's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

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

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

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

**You must include Your Member Identification Number when submitting an appeal.**

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

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

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

**For Out of State Appeals.** you have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

**How Your Appeal will be Decided**

When Anthem considers your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

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

who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination,

### **Notification of the Outcome of the Appeal**

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

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

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

### **Appeal Denial**

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

### **Voluntary Second Level Appeals**

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

### **External Review**

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company

ATTN: Appeals  
P.O. Box 4310, Woodland Hills, CA 91365-4310

**You must include Your Member Identification Number when submitting an appeal.**

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

**Requirement to file an Appeal before taking further legal action**

No legal action of any kind related to a benefit decision may be filed by you in any other forum, unless it is commenced within three years of the plan's final decision on the claim or other request for benefits. If the plan decides an appeal is untimely, the plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the plan's internal Appeals Procedure but not including any voluntary level of appeal, before taking other legal action of any kind against the plan.

**Anthem reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.**

**II. Procedures for Presenting Claims for Legal, Life and Accidental Death and Dismemberment Benefits**

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

In submitting claims for legal, life and accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives a claim for Benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim.

Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date we received the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies the claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife.

This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records, and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records, and other information relevant to the claim.

#### Claims Involving Disability Determinations in connection with Life Insurance

##### Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

##### Claim Submission

For any claim which requires a determination of disability in connection with life insurance, the claimant must complete the appropriate claim form and submit the required proof as described in the certificate. For example, if the Plan provides that you are not required to continue paying for your life insurance coverage after you are found to be disabled, or if the Plan provides that a portion of your life insurance benefits are payable to you after you are found to be disabled, your request for such determination is treated as a claim involving a disability determination.

Claim forms must be submitted in accordance with the instructions on the claim form.

##### Initial Determination

After MetLife receives your claim involving a disability determination, your claim will be reviewed, and you will be notified of the decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date we received your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45-day period (or prior to the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the required information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review

procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

#### Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim.

### **III. Claims and appeal procedures- Severance Pay Plan**

If any person believes he or she is being denied any rights or benefits under the Severance Pay plan, such person may file a claim in writing with the Plan Administrator. If any such claim under the Plan is wholly or partially denied, the Administrator will provide the claimant with a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the specific plan provisions upon which the denial is based, (iii) a description of any additional information the claimant might be required to provide with an explanation of why it is needed, and (iv) an explanation of the Severance Pay Plan's claim review procedure and applicable time limits and a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision upon review.

A written claim denial will be sent within 90 days after receipt of the claim by the Severance Pay Plan. The 90 days may be extended for up to another 90 days if special circumstances warrant an extension of time. If such an

extension is needed, the claimant will be notified in writing prior to the beginning of the extension period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Severance Pay Plan expects to render a decision. The claimant or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the Plan Administrator. In connection with such a request, documents pertinent to the administration of the Severance Pay Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. The claimant may have representation throughout the review procedure.

A request for a review must be filed within 60 days of the claimant's receipt of the written notice of denial of a claim. The full and fair review will be held, and a decision rendered by the Plan Administrator no longer than 60 days after receipt of the request for review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days after receipt of the request for review. If such an extension of time is needed, the claimant will be notified in writing prior to the beginning of the time extension period. The decision after the review will be in writing and will include:

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the claims decision is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits, without regard to whether those records were considered or relied upon in making the adverse claims decision on review, including any reports, and the identifies of any experts whose advice was obtained;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about those procedures; and
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision on review.

#### **IV. Claims and appeal procedures- Health Care Flexible Spending Account**

The plan has established the following claims review procedure in the event you are denied a benefit under this plan.

**Step 1:** *Notice of denial is received from Third Party Administrator (HealthEquity).* If your claim is denied, you will receive written notice from HealthEquity that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of HealthEquity, it may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which HealthEquity must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

**Step 2:** *Review your notice carefully.* Once you have received your notice from HealthEquity, review it carefully. The notice will contain:

- a. the reason(s) for the denial and the Plan provisions on which the denial is based;
- b. a description of any additional information necessary for you to perfect your claim, why the information is necessary and your time limit for submitting the information;
- c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- d. a right to request all documentation relevant to your claim.

**Step 3:** *If you disagree with the decision, file an appeal.* If you do not agree with the decision of HealthEquity, you may file a written appeal. Your appeal must be received within 180 days of the date you received notice that your claim was denied. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

**Step 4:** *Second notice of denial is received from HealthEquity.* If the claim is again denied, you will be notified in writing by HealthEquity as soon as possible but no later than 30 days after receipt of the appeal.

**Step 5:** *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by HealthEquity.

**Step 6:** *If you still disagree with the HealthEquity decision, file a 2<sup>nd</sup> level appeal with the Plan Administrator.* If you still do not agree with the HealthEquity decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from HealthEquity. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your 2<sup>nd</sup> level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Other important information regarding your appeals:

- a. Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- b. On each level of appeal, HealthEquity will review relevant information that you submit even if it is new information; and
- c. You cannot file suit in federal court until you have exhausted these appeals procedures.

## **V. Claims and appeal procedures- John Hancock Long-Term Care Insurance**

### **Presenting claims for benefits**

If your claim for benefits under your John Hancock Long-Term Care Insurance Policy is denied, in whole or in part, you or your authorized representative will receive a written notice giving the reason for the denial. You will then be entitled to a review of the claim denial if:

- You make written request for such review; and
- You send such request to John Hancock within 60 days after receipt of the denial. In your request for a claim review, you should:
  - State why you disagree with John Hancock's determination;
  - State what other factors (if any) John Hancock should take into consideration; and
  - Identify whom John Hancock could contact (including names, addresses, and phone numbers) to gather any additional pertinent information regarding your condition or your care.

John Hancock will make a full and fair review of the claim and may require additional information to objectively evaluate your appeal. John Hancock may use one or more of the following resources for its review:

- a physician who will assess your condition and report it to John Hancock;
- an on-site geriatric assessment; or
- medical records from your physician(s) and/or provider(s) of care.

John Hancock will then review and make a final decision with respect to the claim appeal for benefits under the policy. The decision will be in writing and, if a denial, will include specific reasons for the denial. John Hancock will make its decision regarding your claim promptly and usually not later than 60 days after receiving the request for review.

### **Appeals of adverse determination**

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time



frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to the Plan Administrator within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to and the right to obtain copies of all documents, records and information relevant to your claim free of charge.

A request to the Plan Administrator must be submitted in writing to:

Plan Administrator - John Hancock

University of Southern California 3720 S. Flower Street, 2<sup>nd</sup> Floor, Los Angeles, CA 90007

When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

You will be notified regarding the decision on your claim within 60 days. However, the appeal determination period may be extended for up to 60 additional days in the event the Plan Administrator determines that special circumstances apply. If an extension is necessary, notice will be given to you (or your authorized representative) prior to the end of the appeals determination period. The notice will indicate the special circumstances that apply and the date by which the Plan Administrator reasonably expects to render a decision.

The determination of your appeal will be in writing and, if adverse, will contain the following:

- the specific reasons for the adverse determination of your appeal;
- reference to the specific plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a statement regarding your right to sue under Section 502(a) of ERISA following an adverse determination on your appeal and about any available voluntary alternative dispute resolution options; and
- the statement: “You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

After completing all mandatory appeals levels, you have the right to further appeal adverse eligibility determinations by bringing a civil action under ERISA.

***Please note: For information about appealing a short-term disability or long-term disability claim, please refer to Short Term Disability Summary Plan and/or Long-Term Disability Summary Plan Descriptions.***

## **COBRA notices and information**

### **Group Health Plan continuation coverage under COBRA**

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator or its delegate USC's COBRA administrator is WageWorks).

#### *What is COBRA continuation coverage?*

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under USC's plans, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

If you are an employee of USC ("USC") covered by one of the medical, dental or vision care options (or, in limited cases, a health care flexible spending account) maintained by USC (the "USC Health Plans"), you will become a qualified beneficiary if you lose your group health coverage because your hours of employment are reduced, or your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee covered by the USC Health Plans, you will become a qualified beneficiary if you lose your coverage under the USC Health Plans because any one of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (3) Your spouse's hours of employment are reduced;
- (4) You become divorced or legally separated from your spouse; or
- (5) Your spouse becomes entitled to Medicare (under Part A, Part B, or both).

Your dependent children will become qualified beneficiaries if they lose coverage under the USC Health Plans, because any one of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parents become divorced or legally separated;
- (5) The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- (6) The child ceases to be eligible for coverage under the US C Health Plans as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to USC and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or striving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the USC Health Plans.

#### *When is COBRA coverage available?*

The USC Health Plans will offer COBRA continuation coverage to qualified beneficiaries only after WageWorks has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in a bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify WageWorks of the qualifying event.

*You must give notice of some qualifying events*

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify WageWorks within 60 days after the qualifying event occurs. You must provide this notice to WageWorks at the address, phone number or e-mail address provided at the end of this section, along with documentation substantiating the divorce, legal separation or loss of dependent status and the effective date of such event.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and be added to the covered employee's COBRA continuation coverage. You must notify WageWorks within 60 days after the birth or placement for adoption occurs. You must provide this notice to WageWorks at the address, phone number or e-mail address provided at the end of this section, along with copies of legal documents substantiating the birth or placement for adoption and the effective date of such event.

*How is COBRA coverage provided?*

Once WageWorks receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A Part B, or both), your divorce, legal separation, or a dependent child's losing eligibility as a dependent child. COBRA continuation coverage lasts for up to a total of 36 months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment. COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

*Disability extension of 18-month period of continuation coverage*

If you or anyone in your family covered under USC Health Plans is determined by the Social Security Administration to be disabled and you notify WageWorks within 60 days of the Social Security Administration's disability determination and before your initial 18-month period of continuation coverage expires, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must also notify WageWorks within 30 days of the date of any final determination by the Social Security Administration that he or she is no longer disabled. You must provide these notices to WageWorks at the address, phone number or e-mail address provided at the end of this section, along with copies of correspondence from the Social Security Administration substantiating the disability/loss of disability and the effective date of the applicable SSA determination. Furthermore, during the period after the 18th month through the 29th month of continuation coverage, the monthly premium cost will be increased to 150% of the applicable premium relating to continuation coverage.

*Second qualifying event extension of 18-month period of continuation coverage*

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to WageWorks. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under USC Health Plans as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plans had the first qualifying event not occurred.

*Are there other coverage options besides COBRA continuation coverage?*

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace. Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.Healthcare.gov](http://www.Healthcare.gov).

You should also take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. *Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?*

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later.

If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>

*How can you elect COBRA continuation coverage?*

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not.

Continuation coverage maybe elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

*How much does COBRA continuation coverage cost?*

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary must pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to disability, 150 percent) of the cost to the USC Health Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

*When and how must payment for COBRA continuation coverage be made?*

If you elect continuation coverage, you have up to 45 days after the date of your election to send your first monthly premium payment, made payable to USC, to WageWorks at the address provided at the end of this notice. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the USC Health Plans. You are responsible for making sure that the amount of your first payment is correct. You may contact WageWorks to confirm the amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make monthly premium payments that are due on the first day of each month. You will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make monthly payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the USC Health Plan.

#### *Early termination of COBRA*

COBRA provides that your continuation coverage may be terminated before the end of the maximum coverage period for any of the following reasons:

- (1) USC no longer provides group health coverage to any of its employees;
- (2) Any required premium for continuation coverage is not paid in full on time;
- (3) A qualified beneficiary becomes covered-after electing COBRA continuation coverage-under another group health plan (as an employee or otherwise).
- (4) A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage;
- (5) A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

#### **If you have questions**

More complete information regarding your COBRA continuation coverage rights is available from WageWorks. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the marketplace, visit [www.Healthcare.gov](http://www.Healthcare.gov).

#### **How to contact WageWorks**

WageWorks (888-678-4881)

#### **Keep your plan informed of address changes**

In order to protect your family's rights, you should keep the Office of Benefits Administration informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Office of Benefits Administration.

#### Plan Contact Information

Office of Benefits Administration, University of Southern California 3720 S. Flower Street, CUB 200, Los Angeles, CA 900890704, (213) 821-8100, [uschr@usc.edu](mailto:uschr@usc.edu).

#### **Other required notices under federal law**

#### **Special enrollment periods-HIPAA**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the health care options offered by USC, provided that you request enrollment within 30 days after (i) your other coverage is terminated due to your or your dependents' loss of eligibility, (ii) employer contributions toward such other

coverage ceased, or (iii) if the other coverage was COBRA coverage, your COBRA coverage was exhausted. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

#### **Special Enrollment Periods - Children's Health Insurance Plan Reauthorization Act**

Employees and their eligible dependents will be allowed to enroll in the USC group health plan if one of the two following events occur:

1. The employee's or dependents' Medicaid or State Children's Health Insurance Plan (SCHIP) coverage is terminated due to a loss of eligibility, or
2. The employee or dependent becomes eligible for a premium subsidy under Medicaid or SCHIP.

Employees must request enrollment within 60 days of the effective date of the loss of Medicaid or SCHIP coverage or becoming eligible for the premium subsidy.

#### **Maternity Stays—Newborns' and Mothers' Health Protection Act**

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

#### **Women's Health and Cancer Rights Act**

Under the Women's Health and Cancer Rights Act of 1998, health plans that provide coverage for mastectomies must also cover reconstructive breast surgery following the mastectomy, including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearances; and
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

Coverage for the procedures will be the same as that for any other medical/surgical benefit under the health plan you have elected, and certain general coverage limitations may apply, including, but not limited to, deductibles, co-insurance, co-payments, reasonable and customary charges, approval of your primary care physician, etc. Please refer to your HMO Evidence of Coverage or Network Plan booklet.

**Genetic Information Nondiscrimination Act of 2008 (GINA).** In addition, under the Genetic Information Nondiscrimination Act of 2008 (GINA), neither an insurance provider nor your employer may not discriminate against you on the basis of genetic information, including by adjusting premiums and contribution amounts.

**Continuation of Health Care Benefits (USERRA).** The Uniformed Services and Employment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service. Except to the extent greater benefits are provided by USC, the maximum length of extended coverage under USERRA is the lesser of (1) 24 months beginning on the date that the military leave begins; or (2) a period beginning on the day that the leave began and ending on the day after your reemployment application deadline. If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods. However, exceptions may apply to an illness or injury incurred as a result of the military service.

**Patient Protections under the Patient Protection and Affordable Care Act.** The Anthem Blue Cross HMO Plan generally requires the designation of a primary care provider. You have the right to designate any primary care

provider who participates in the Anthem Blue Cross network and who is available to accept you or your family members. Until you make this designation, Anthem Blue Cross designates one for you. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem Blue Cross or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at:

University of Southern California  
851 Downey Way, HSH 10 IB, Los Angeles, CA 90089-1057, (213) 740-0035

### **Summary of HIPAA Privacy Rights**

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to protect the confidentiality of your private health information. The university and its group health plans will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the group health plans will require all of its business associates to also observe HIPAA’s privacy rules. In particular, the group health plans will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

Under HIPAA you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable plan or with the Secretary of the U. S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. The plans maintain a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, please contact USC Health Plans. If you have questions about the privacy of your health information, please contact USC Health Plans or the university’s designated privacy official.

### **Compliance with applicable laws**

The Plans described in this Summary Plan Description (SPD) shall be interpreted and administered in accordance with applicable law, as determined by the Plan Administrator in its sole discretion. If the Plan Administrator determines that any provision in this SPD conflicts with such applicable law, the Plan Administrator, in its sole discretion, may adopt an interpretation that avoids or removes that conflict, and the applicable Plan shall be deemed to be automatically amended to reflect that interpretation of the Plan Administrator.