

UCSD MEDICAL CENTER

FOR YOUR BENEFIT

MEDICAL::DENTAL::VISION::LIFE::LONG
TERM DISABILITY PLANS



UNIVERSITY *of* CALIFORNIA
SAN DIEGO

MEDICAL CENTER

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GENERAL INFORMATION

This book covers the important features of your benefits but is not intended to be a contract or a replacement of the official plan documents, which legally govern the plans. These documents are available from the UCSD Medical Center Office of Graduate Medical Education website at <http://ogme.ucsd.edu>.

Any questions about the interpretation of any information regarding your benefits, or the proper payment of benefits, should be directed to the Office of Graduate Medical Education. Final interpretation of any specific provision is governed by the master policy or plan document.

UCSD Medical Center is committed to providing these important benefits to you. However, we reserve the right, at any time, to make changes in the benefits, eligibility requirements, or levels of participant contribution as well as employer contribution. The UCSD Medical Center also reserves the right to terminate any of the plans at any time.

ELIGIBILITY

Interns, residents, and clinical fellows under the purview of the UCSD Office of Graduate Medical Education are eligible to enroll in the UCSD Medical Center benefit plans.

EFFECTIVE DATE OF COVERAGE

Your benefit coverage is effective the date of your appointment to UCSD Medical Center as long as you are actively at work on that day. Coverage for your dependents is effective the same day as your coverage unless they are currently (or have been in the last 31 days) medically confined at home or elsewhere. Please contact the Office of Graduate Medical Education if this applies to your dependents.

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependent provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Enrollment forms are available on the Office of Graduate Medical Education website at <http://ogme.ucsd.edu>.

ENROLLMENT REQUIRED

Your medical, dental, vision, life, and long term disability insurance coverage is not automatic. You must select your coverage and submit enrollment forms to the Office of Graduate Medical Education no later than 30 days after your appointment date.

DEPENDENT COVERAGE

You may cover your legal spouse, your unmarried children who are less than 19 years of age or less than 25 years of age if a full-time student depending solely upon you for support, or age 19 or older and incapable of self-support due to mental or physical handicap, and/or your domestic partner and his/her children.

In order to cover a domestic partner, a signed Affidavit of Domestic Partnership must be provided. This affidavit indicates that the employee and domestic partner: (1) are not related to each other, (2) have

assumed mutual obligations for the welfare and support of each other, (3) have been living together as a couple in the same household for at least six months, and (4) have not had a different partner less than six months before the date of the affidavit.

Your dependent coverage begins the same day your own coverage becomes effective, or the day you apply for dependent coverage, if later.

PLAN YEAR

The plan year is July 1-June 30. An open enrollment is held during the month of June, at which time you will have the opportunity to change your medical plan coverage.

COORDINATION OF BENEFITS

The amount of benefits payable under UCSD Medical Center's health plans will take into consideration any coverage you or your dependents have with other group health plans.

If you and your spouse both have coverage on separate plans for your dependent children, the parent whose birthday is first during the calendar year will be the primary plan for the dependent children and will pay first. The parent with the later birthday has the secondary plan and it will pay second.

In the event UCSD Medical Center is the secondary provider and your dependents are covered under our plan and another employer's health plan, UCSD Medical Center's plan will coordinate its benefits with the other plan by paying as follows:

- The other health plan (primary plan) will calculate its benefits and pay first.
- Our plan (as secondary plan) will then calculate its allowable benefits and then subtract the amount paid by the primary plan.

TERMINATION OF COVERAGE

Coverage for you and your dependents will cease automatically in the event of one of the following:

- Your termination from UCSD Medical Center
- You no longer are benefits-eligible
- The plan terminates

Your dependent coverage will cease automatically in the event of the above, as well as upon:

- Divorce or legal separation
- Termination of dependent eligibility
- Dependent becomes covered as an employee under the plan

CONTINUATION OF COVERAGE OPTION

EXTENSION OF BENEFITS

If you or your covered dependent is totally disabled on the date of termination of the UCSD Medical Center policy with Blue Cross, your benefits will be available while you are disabled for up to 12 months.

COBRA

You will have the option of continuing your medical, dental, and vision plan benefits at your own expense upon termination of your plan coverage for any of the reasons listed in the previous section. You and your covered dependents will receive the detailed information, enrollment forms, and related costs necessary to continue your coverage following termination of coverage. You and your dependents are then responsible for requesting continuation of benefits by notifying the Office of Graduate Medical Education and by completing a Notice to Elect Continued Coverage form within 60 days of the date of the qualifying event or the notification from UCSD Medical Center, whichever occurs later. Continued coverage will terminate if and when you or your dependents become covered under another health plan, you fail to pay the required cost, or the continuation period ends. If you are age 60 or older at termination, you may be eligible for an additional extension of COBRA coverage. Information on COBRA including deadlines, costs, and enrollment forms are available on the Office of Graduate Medical Education website at <http://ogme.ucsd.edu>.

TERMINATION OF APPOINTMENT

If you terminate your appointment, you and/or your eligible dependents may enroll for up to 18 months of continued health plan coverage. If you or your dependent(s) became disabled prior to the end of the 18-month period, and have been determined disabled under Title II or Title XVI of the Social Security Act, you must notify the Office of Graduate Medical Education within the first 18 months of COBRA coverage of your receiving the Social Security disability determination to continue coverage up to 29 months, and you must be determined to be disabled during the first 60 days of COBRA continuation coverage. Effective January 1, 2003, under the California COBRA program (CAL-COBRA), employees covered by insurance plans written in the state of California will have the option of continuing medical coverage for an additional 18 months.

TERMINATION OF DEPENDENT COVERAGE

If a dependent's benefits end because he/she no longer meets the definition of an "eligible dependent," health plan coverage may be continued for up to 36 months.

FAMILY DEATH BENEFITS

If your death occurs, your covered dependent(s) may continue their health plan coverage for a total of 36 months.

NEWBORN OR ADOPTED CHILDREN

If you have a newborn or adopted child while on COBRA continuation and you enroll the new child for coverage, the new child will be considered a qualified beneficiary rather than merely an after-acquired dependent, which gives the child additional COBRA rights. These include the right to continue COBRA

benefits even if you die and the right to an additional 18 months of coverage if a second qualifying event occurs.

DIVORCE OR LEGAL SEPARATION

If you become divorced or legally separated, your spouse (or former spouse, if divorced) may enroll for up to 36 months of continued health plan coverage.

Benefits for the dependent children of a divorced or legally separated employee may also be continued for up to 36 months. The party responsible for payment of the plan cost may be determined by a court decree or other legal settlement.

EXPIRATION OF COBRA COVERAGE

Health plan coverage for a covered participant will stop immediately if he/she becomes covered under another group health plan, becomes eligible for Medicare benefits, fails to pay the required costs, or if group plans provided by the employer are terminated. An exception is allowed if coverage under another group plan excludes a pre-existing medical condition.

CONVERSION

If you have Blue Cross medical, Standard life, or Standard long term disability coverage, under the terms of these contracts, you have 31 days to apply for conversion coverage. Conversion forms are available on the Office of Graduate Medical Education website at <http://ogme.ucsd.edu>.

IMPORTANT DEFINITIONS

The following definitions are included only as general information. Specific definitions applicable to each individual plan coverage may be found in the plan documents. Contact the Office of Graduate Medical Education if you need a specific definition as it applies to one of the benefit plans.

Accidental injury: Physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place.

Accidental injury does not include illness or infection, except infection of a cut or wound.

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

Authorized referral: An authorized referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

- There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
- You are referred in writing to the non-participating provider by the physician who is a participating provider, and
- The referral has been authorized by Blue Cross before services are rendered.

Calendar year: A period of one year beginning with January 1.

Co-insurance: A percent of an expense that is paid by the insurance company for medical/dental services.

Co-payment: A fixed amount that is paid by you to a provider for medical or dental services.

Cosmetic surgery: Surgery performed to reshape normal structures of the body and intended solely to improve the appearance of the individual.

Covered expense: The expense you incur for a covered service or supply, but not more than the maximum amounts described in the two bullets below. Expense is incurred on the date you receive the service or supply.

Covered expense does not include:

- For all participating providers, any charge in excess of the negotiated rate; or
- For non-participating providers and other health care providers: (a) any charge by a physician in excess of the customary and reasonable charge; or (b) any charge by a hospital or other health care provider in excess of a reasonable charge.

Exception: If Medicare is the primary payor, covered expense does not include any charge: (1) by a physician in excess of the customary and reasonable charge; or (2) by a hospital or other health care provider in excess of a reasonable charge.

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

Deductible: The amount of expenses you pay annually before the PPO medical plan begins paying. A new deductible applies each calendar year.

Dependents: Your spouse and your unmarried children under age 19 or until age 25 while a full-time student, your domestic partner and his/her children, or other qualified dependents as determined by the plan carrier.

Domestic partner is the subscriber's domestic partner under a legally signed Affidavit of Domestic Partnership. This affidavit indicates that you and your domestic partner: (1) are not related to each other, (2) have assumed mutual obligations for the welfare and support of each other, (3) have been living together as a couple in the same household for at least six months, and (4) have not had a different partner less than six months before the date of the affidavit.

Spouse is the subscriber's spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (1) covered as a subscriber, or (b) is in active service in the armed forces.

Child is the subscriber's or spouse's unmarried natural child, stepchild, or legally adopted child, subject to the following:

- The child depends on the subscriber or spouse for financial support or the subscriber or spouse is legally required to provide group health coverage for the child pursuant to a court or administrative order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
- The unmarried child is under 19 years of age, or if over the age of 19, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 12 or more credits) in a properly accredited two-year community college, four-year college or university, or an accredited post-high school trade or technical school.
- A child who is in the process of being adopted is considered a legally adopted child if Blue Cross receives legal evidence of both: (i) the intent to adopt; and (ii) that the subscriber or spouse have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form or relinquishment form signed by the child's birth parent or other appropriate authority, or in the absence of a written document, other evidence of the subscriber's or the spouse's right to control the health care of the child.
- The term "child" does not include: (i) any child for whom the subscriber is the legal guardian, but who is not the subscriber's natural child, stepchild, or adopted child; (ii) any person who is covered as a subscriber; or (iii) any person who is in active service in the armed forces.
- If both parents are covered as subscribers, their children may be covered as the family members of either, but not of both.

Durable medical equipment: Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other 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.

Hearing aids and related services are covered under durable medical equipment.

Elective surgery: A surgical procedure which is scheduled in a nonemergency situation (i.e. where the procedure can be delayed, at least temporarily, without endangering the patient's life or health).

Emergency: A sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with Blue Cross.

Health maintenance organization (HMO): A health care plan that typically requires members to use only participating doctors and facilities. Care must be directed by a primary care physician to be eligible for benefit coverage.

Medically necessary: Services or supplies which Blue Cross determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, the convenience of your physician or another provider; and
- The most appropriate supply or level of service which can safely be provided. For hospital stays, this means that acute care as an inpatient is needed due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Mental health and chemical dependence: Refer to special provisions within the plan for specific coverage, exclusions, and limitations.

Out-of-pocket expenses: The amount of eligible health care expenses you are responsible for paying after the deductible is met.

Plan year: A period beginning July 1 and ending 12 months later on June 30.

Preferred provider organization (PPO): An organization consisting of hospitals, physicians, and other health care providers who offer their services to employer plans at a reduced rate.

Utilization review program: A program of reviewing hospital admissions before and as they occur to assure medical necessity for confinement and to monitor the length of hospital stays.

MEDICAL PLANS

UCSD Medical Center offers you a choice of two Blue Cross medical plan options: (1) the Preferred Provider Organization (PPO) plan, or (2) a Health Maintenance Organization (HMO) plan.

BLUE CROSS PPO

With the Blue Cross PPO, you may use any accredited medical service provider. If you receive services at the UCSD Medical Center, the plan pays 100%. Additionally, eligible services at Children's Hospital of San Diego will be paid at 100% limited to the following providers: Children's Hospital of San Diego, Children's Specialists of San Diego, San Diego Diagnostic Radiology, Anesthesia Service Medical Group, and Sharp and Children's MRI. There is no deductible, but a co-pay is applicable for office visits and emergency care. If you use providers who participate in the Prudent Buyer preferred provider organization (PPO), the plan pays 80% after satisfaction of the deductible. A co-pay is applicable to office visits and emergency care. A directory lists the more than 3,619 county PPO physicians, clinics, labs, and hospitals. If you use non-PPO providers, the plan pays 60% of customary and reasonable charges after satisfaction of the deductible.

For prescription drugs, the co-pay for a generic drug is \$12. The brand drug co-pay is \$12 plus the difference in cost between generic and brand. If there is no generic equivalent, the co-pay is \$18. You can order a 90-day supply of maintenance drugs through the mail-order program for a \$25 co-pay for generic drugs and a \$35 co-pay for brand drugs.

Refer to the Medical Plans Summary on page 22 for more detailed information about percentage paid.

PRE-EXISTING CONDITIONS EXCLUSIONS AND LIMITATIONS

Both federal law (The Health Insurance Portability and Accountability Act of 1996, known as "HIPAA") and California law limit the circumstances under which a group health plan may exclude coverage for medical conditions present before an individual enrolled. Since the plan is governed by both laws, the following rules apply:

1. **Pre-existing Conditions Limitation.** This plan imposes a pre-existing condition limitation, which excludes coverage during your first six (6) months of plan participation for a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to your "enrollment date." Your enrollment date is the earlier of the date coverage actually begins or the first day of any waiting period. Thus, your enrollment date is your effective date of your appointment. The plan's pre-existing condition exclusion period must be reduced by your prior "creditable coverage" (which includes most types of group or individual health coverage) if you did not have a gap in coverage of more than 180 days. However, if your prior coverage was individual coverage, it will offset the pre-existing condition period only if your gap in coverage was not more than 62 days. In either case, any time you spent in a waiting period for coverage under another employer's plan will not be counted toward 180 or 62 days.

Notwithstanding the above paragraph, a pre-existing condition limitation will not be imposed (a) for pregnancy or conditions resulting from pregnancy, or against a newborn or newly adopted child who was covered within 30 days after birth or adoption or placement for adoption; and (b) for covered services for the treatment of mental or nervous disorders or substance abuse.

2. **Certifications or Other Evidence of Prior Coverage.** The primary method by which new enrollees (employees or dependents) will provide evidence of their prior health coverage is through a certificate provided by the prior employer or plan. However, if you do not have a

certificate of prior coverage, you may provide other evidence of such coverage, such as a health insurance ID card, pay stubs showing withholding for medical coverage, explanations of benefits, a certificate of coverage under a group policy, or any other relevant documents that evidence periods of health coverage. You must also sign a statement attesting that you had coverage for the period at issue, and you must cooperate with us in verifying your prior coverage, including authorizing us to obtain evidence of coverage from your prior employer(s) or plan(s).

3. **“Special Enrollment Rights.”** If you do not enroll for coverage when you are first eligible but you later wish to enroll, you may not be able to do so until 12 months after you notify the Office of Graduate Medical Education that you wish to enroll. At that time, a six-month pre-existing condition limitation will apply to you. However, these restrictions will not apply to you if you meet the following criteria for “Special Enrollment Rights”:
 - a. If you decline 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 this plan, provided that you request enrollment within 31 days after your other coverage ends. This special rule applies if you or your dependents lose the other coverage due to termination of employment, change in employment status, termination of the other plan’s coverage, cessation of the employer’s contribution toward coverage, exhaustion of COBRA coverage, death of a spouse, or divorce.

Even if you do not meet the 31-day requirement, the plan must allow you to enroll if you did not initially sign a written waiver of coverage stating that the reason you were waiving coverage was because you had other coverage and acknowledging that such waiver may cause you (and your dependents) to be treated as a late enrollee if you subsequently request enrollment. A six-month preexisting condition exclusion would then apply.

- b. If you have a new dependent as a result of a 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. If you are eligible for coverage but do not enroll, your dependent cannot enroll.
 - c. If a court of competent jurisdiction orders coverage of a spouse or minor child, that individual may be enrolled mid-year if the request for enrollment is made to the employer within 30 days of the court order.

BENEFITS DURING FAMILY AND MEDICAL LEAVE OR PREGNANCY DISABILITY LEAVE

If you are on a leave of absence approved by your department chair and the UCSD Medical Center, and your leave is protected under the Federal Family and Medical Leave Act (FMLA) and the California Pregnancy Disability Leave laws (PDL), you may continue your medical, dental, and optical benefits during such leave of absence. Contact the Office of Graduate Medical Education for details on eligibility for, and terms and conditions of, an approved leave of absence.

While you are on FMLA leave, the Medical Center will continue to pay its regular share of the insurance premium (for individual or dependent coverage), up to a maximum of 12 workweeks within a 12-month period. If the need for family and medical leave **that is in progress** expands beyond 12 workweeks, you shall be entitled to a supplemental leave for up to 12 workweeks or until the end of the leave year, whichever is less. During this period of supplemental leave, the Medical Center will continue to pay its regular share of the insurance premium for individual or dependent coverage. If the leave of absence continues longer than 24 workweeks, you must elect and pay for COBRA to continue medical, dental, and optical coverage.

MATERNITY MINIMUM STAY PROVISIONS

The Newborns' and Mothers' Health Protection Act generally prohibits group health plans and health insurance issuers offering group insurance coverage from:

1. Restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section; or
2. Requiring that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

HOSPITAL PRE-CERTIFICATION

For scheduled, non-urgent admissions to any hospital, it is your responsibility to have the days of confinement certified. This must be done at least three working days prior to the date of scheduled admission.

If the admission is an emergency or an urgent admission, the confinement must be certified either before an urgent admission or no later than one working day after an emergency admission unless extraordinary circumstances prevent such notification within that time period.

If you do not receive hospital pre-certification as required, you will be responsible to pay an additional \$500 deductible. The pre-certification deductible will not apply to emergency admissions or services, nor to the services provided by a participating provider. For certification, call the phone number shown on your plan ID card.

PREGNANCY COVERAGE

Medical benefits are payable for pregnancy-related expenses on the same basis as for disease, whether or not the pregnancy commences while the individual is covered under this plan.

ROUTINE CARE

Covered services provided in a routine physical for children under age 17 include:

- A review and written history of the child's complete medical history
- Taking body measurements and blood pressure
- Developmental and behavioral assessment
- Vision and hearing screening
- One series of hereditary and metabolic tests performed at birth
- Urinalysis, tuberculin test, and blood tests
- Immunizations for infectious disease
- Counseling of child and parents regarding results of a physical exam

Covered services for a routine physical are provided for adults over age 17, up to \$250 per calendar year.

Consult your plan certificate for services not covered under preventive care, and refer to the Medical Plans Summary on page 22 for routine care benefits.

MAMMOGRAMS

Coverage under the Blue Cross PPO plan includes routine and diagnostic mammogram examinations to detect breast cancer.

CERVICAL CANCER SCREENING

Services and supplies provided in connection with a routine test to detect cervical cancer (i.e., Pap smear) are covered under the Blue Cross PPO plan.

MENTAL OR NERVOUS DISORDERS OR SUBSTANCE ABUSE

Covered services are shown below for the treatment of mental or nervous disorders or substance abuse, provided such services offer a reasonable expectation of improvement, and a level of care consistent with safe medical practice.

- Inpatient hospital services
- Outpatient visits to a day treatment center
- Physician's visits during a covered inpatient stay or for outpatient psychotherapy or psychological testing

If care is sought away from UCSD, in order to receive coverage at the Tier 2 level, services must be rendered by a Blue Cross WellPoint Behavioral Health Provider.

The total amount payable for all covered services for the treatment of substance abuse will not exceed a maximum of \$50,000 lifetime.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

The Mental Health Parity Act of 1996 became effective on January 1, 1998. The House Staff Group Medical plans were updated effective July 1, 1998, pursuant to and in compliance with this important legislation.

The Mental Health Parity Act of 1996 prohibits group plans from imposing annual or lifetime dollar benefit limits for mental health expenses that differ from those for medical and surgical expenses.

While the act does not mandate coverage for mental health benefits, it does require health plans that offer mental health benefits to comply with the act's requirements. Accordingly, the \$50,000 lifetime maximum coverage limit for mental health/substance abuse now applies only to the substance abuse benefit.

Effective July 1, 2000, the Mental Health Coverage Assembly Bill 88 requires coverage for the diagnoses and treatment of severe mental illnesses in people of all ages and serious emotional disturbances of children, as defined, under the same terms and conditions applicable to medical conditions. Benefits affected are inpatient hospital services, outpatient services, partial hospitalization, and drugs. Severe mental illnesses include (but are not limited to):

Schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

Serious emotional disorders of children are mental disorders causing behavior inappropriate to the child's age based on expected norms (but not substance disorder or developmental disorder). The child must meet other criteria, as set forth in the Welfare and Institutions Code.

This coverage may be provided separately and may be subject to case management and utilization review.

THIRD PARTY REIMBURSEMENT

No payment will be made under this plan for expenses incurred for or in connection with any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation. However, Blue Cross will provide the benefits of this plan subject to the following:

- Blue Cross will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits paid by Blue Cross under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable.
- You must advise Blue Cross in writing within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as Blue Cross may require to facilitate enforcement of its rights. You must not take action which may prejudice the rights or interest of Blue Cross under your plan. Failure to give such notice to Blue Cross or cooperate with Blue Cross, or actions that prejudice the rights or interests of Blue Cross will be a material breach of this plan and will result in your being personally responsible for reimbursing Blue Cross.

BLUE CARD BENEFIT

When traveling outside of California, you will have access to a broader network of physicians and hospitals offering significantly discounted rates. These benefits are all part of the Blue Card PPO program.

The Blue Card PPO network includes 77% of hospitals and 72% of physicians nationwide. Their discounts average 30% for inpatient services, 24% for outpatient services, and 23% for physician services. These increased discounts will result in lower out-of-pocket costs for you.

In addition to enjoying deeper discounts nationwide with the Blue Card network, you will be able to call a toll-free number (800/810-BLUE) to retrieve information regarding doctors you may need to see in the city you're visiting. When you use the toll-free number, you will be automatically routed to a Blue Cross/Blue Shield plan staff member who can provide more information on providers in the area you request.

You can still obtain traditional discounts, if you choose to receive medical services from participating providers who are not part of the Blue Card PPO network. However, if there is a PPO provider available in the same area and you choose to see a non-participating PPO provider, the claim will be paid at the plan's lower benefit level. If there is no PPO provider in the same area, the claim will be paid at the higher level.

EXCLUSIONS AND LIMITATIONS

Except as stated in the specific provisions of the plan document, Blue Cross Prudent Buyer PPO does not cover:

- Services and supplies determined to be not medically necessary.
- Any experimental or investigative procedure or medication.
- Services received before your effective date of coverage or during an inpatient stay that began on or before your effective date; services received after your coverage ends, except as specifically stated under extension of benefits.
- Any amounts in excess of covered expense or the lifetime maximum.
- Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.
- Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.
- Conditions that result from commission of or attempt to commit a felony.
- Conditions that result from any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Professional services provided or received from a person who lives in your home, or who is related to you by blood or marriage, except as specifically stated in the home infusion therapy provision of the plan.
- Services for which you have no legal obligation to pay, or which were made only because there is coverage.
- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Smoking cessation programs or treatment of nicotine or tobacco use.
- Braces, other orthodontic appliances, or orthodontic services.
- Dental plates, bridges, crowns, caps, or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders of the jaw joint (except TMJ, which is covered), cosmetic dental surgery or other dental services for beautification.
- Optometric services, eye exercises, including orthoptics, routine eye exams and routine eye refractions, eyeglasses, or contact lenses.
- Outpatient occupational therapy, except by a home health agency, visiting nurse association, hospice, or home infusion therapy provider.
- Outpatient speech therapy.
- Cosmetic surgery or other services solely for beautification or to improve appearance. This exclusion does not apply to reconstructive surgery to restore a bodily function, or to correct a deformity caused by injury, or medically necessary surgery performed to restore symmetry incident to a mastectomy.
- Services primarily for weight reduction or treatment of obesity. Does not apply to treatment of morbid obesity if authorized in advance.
- Procedures or treatments to change characteristics of the body to those of the opposite sex.
- Reversal of sterilization.

- Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
- Orthopedic shoes (except when joined to braces) or shoe inserts.
- Air purifiers, air conditioners, or humidifiers.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy; custodial care, rest cures, or treatment of chronic pain; services provided by a rest home, a home for the aged, a nursing home or any similar facility; services provided by a skilled nursing facility for custodial care.
- Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including but not limited to charges for a physical fitness instructor, health club, or gym, even if ordered by a physician.
- Supplies for comfort, hygiene, or beautification.
- Educational services or nutritional counseling.
- Telephone consultations.
- Acupressure or massage to control pain, treat illness, or promote health.
- Eye surgery solely or primarily for the purpose of correcting refractive eye defects; contact lenses and eyeglasses required as a result of this surgery.
- Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement.
- Non-prescription, over-the-counter patent or proprietary drug or medicine, cosmetics, dietary supplements, health, or beauty aids.
- Inpatient or outpatient services of a private duty nurse.
- Services not specifically listed in this plan as covered services.
- Any services provided by a local, state, or federal government agency, except when payment under this plan is expressly required by federal or state law.

BLUE CROSS HMO

The Blue Cross Health Maintenance Organization (HMO) requires that you receive medical care from your primary care physician and other network doctors and hospitals to which your primary care physician refers you. If you choose to seek care on your own without a certified referral from your primary care physician, medical services will not be covered unless it is an emergency.

When you enroll in the Blue Cross HMO, you and each covered family member choose a primary care physician within a Medical Group or Independent Practice Association (IPA) of your choice. Your primary care physician directs all your medical care. Each family member may select a different Medical Group or IPA.

If specialist services are necessary, your primary care physician will refer you directly to a specialist.

You may change your primary care physician by selecting another primary care physician from your Provider Directory. Call the number on your member ID card to make the change. After the change is approved, you will receive a new member ID card indicating your new primary care physician. Although

you are permitted to change your primary care physician, it is to your benefit to select and stay with a provider who can get to know your medical history and establish continuity of care.

Under the Blue Cross HMO, there is no pre-existing condition limitation.

PRESCRIPTION DRUG PROGRAM

Prescriptions may be filled at any participating pharmacy when you show your member ID card and pay the co-pay amount. Your per-prescription co-pay at participating pharmacies is \$10 for brand, \$5 for generic for a 30-day supply. When using the mail order program, your days supply increases to 60 days. Prescriptions filled at non-participating pharmacies are paid at 50% of a fee schedule after the applicable copay. **The UCSD Medical Center pharmacy is a participating pharmacy.**

EMERGENCY SERVICES

An emergency is a sudden, serious, and unexpected illness, injury or condition, including severe pain, requiring immediate medical attention. If an emergency arises, go to the nearest hospital. If admitted to the hospital, you or someone on your behalf must call your medical group within 48 hours of the admission to certify care. Failure to certify care may result in non-payment of the claim.

AWAY FROM HOME CARE

As a member of CaliforniaCare, you automatically become part of HMO Blue USA, the largest HMO network in the country. HMO Blue USA is sponsored by the Blue Cross and Blue Shield Association.

A special feature of HMO Blue USA is the away from home care benefits. These benefits cover urgent care, those not so serious illnesses, for you and your family when traveling outside of California.

To access away from home care, call the HMO Blue USA Customer Service representative at the toll-free number printed on your CaliforniaCare ID card. The representative will help you locate an HMO provider within the area. You then call the physician and schedule an appointment – just like you would with your Primary Care Physician at home.

Life threatening emergencies are a different matter. In emergencies, you should immediately go to a hospital and then notify CaliforniaCare – just as you would do if you were in California.

GUEST MEMBERSHIP

You may also apply for guest membership to HMOs located in many regions of the United States. Guest membership is the convenient way to maintain your HMO coverage while you are outside of your service area. It's available to long-term travelers, students, and families living apart.

Guest membership offers temporary HMO services from a "host" HMO located in a region that is outside of your "home" HMO service area. To qualify, you, your spouse, or dependent must be outside of your HMO service area for at least 90 consecutive days. The guest membership is a temporary benefit – long-term travelers cannot be outside of their service area longer than 180 days. However, your family members may have access to guest membership throughout the plan year.

To apply for guest membership, contact CaliforniaCare Customer Service at 800/876-1119. Ask to speak to a Guest Membership Coordinator. The Coordinator will ask you which type of coverage you need (long-term traveler, student, or families living apart). The Coordinator will then assign a "host" HMO to you and give you a contact name and telephone number.

You may also call 800/876-1119 to receive more information about the guest membership program.

MENTAL HEALTH/SUBSTANCE ABUSE

You may get care for the treatment of mental or nervous disorders or severe mental disorders without getting an OK from your medical group. In order for this care to be covered, you must go to a Blue Cross HMO provider. Some services may require that Blue Cross reviews and approves care in advance. A provider listing can be referenced at www.bluecrossca.com.

Coverage for mental health services is as follows:

<i>Inpatient</i>	\$100 co-pay/day, limited to 30 days per calendar year
<i>Outpatient</i>	100% after \$35 co-pay, limited to 20 visits* during each 12-month period

Substance abuse coverage is as follows:

<i>Detox</i>	100% (inpatient)
<i>Outpatient</i>	100% after \$35 co-pay/day, limited to 20 visits* during each 12-month period

* Maximums are combined limits for mental health/substance abuse treatment.

Effective July 1, 2000, the Mental Health Coverage Assembly Bill 88 requires coverage for the diagnoses and treatment of severe mental illnesses in people of all ages and serious emotional disturbances of children, as defined, under the same terms and conditions applicable to medical conditions. Benefits affected are inpatient hospital services, outpatient services, partial hospitalization, and drugs. Severe mental illnesses include (but are not limited to):

Schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

Serious emotional disorders of children are mental disorders causing behavior inappropriate to the child's age based on expected norms (but not substance disorder or developmental disorder). The child must meet other criteria, as set forth in the Welfare and Institutions Code.

This coverage may be provided separately and may be subject to case management and utilization review.

FAMILY PLANNING

Coverage for family planning services is as follows:

Voluntary sterilization

Male	100% after \$100 co-pay
Female	100% after \$150 co-pay

Voluntary abortion 100% after \$150 co-pay

Infertility testing 50% of customary and reasonable charges (co-pay amount is not applicable to the annual co-payment maximum)

EXCLUSIONS AND LIMITATIONS

CaliforniaCare HMO does not cover:

- Services or supplies that are not medically necessary.

- Services or supplies not authorized by your primary care physician or medical group, except for emergency treatment.
- Any experimental or investigative procedure or medication.
- Services received before your effective date or during an inpatient stay that began on or before your effective date, and services received after your coverage ends.
- Services not specifically listed in this plan as covered services.
- Conditions that result from your commission of or attempt to commit a felony.
- Conditions that result from any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Any services provided by a non-participating provider, except for referral or emergency services.
- Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.
- Any services provided by a local, state, or federal government agency, except when payment under this plan is expressly required by federal or state law.
- Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital.
- Chronic or rehabilitative therapy for delays in development; chronic conditions not reasonably expected to improve with short-term, intensive symptom-focused treatment; services primarily for correction of speech disorders, including but not limited to, stuttering or stammering.
- Smoking cessation programs or treatment of nicotine or tobacco use.
- Dental plates, bridges, crowns, caps, or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, cosmetic dental surgery or other dental services for beautification except as specifically stated in the "dental care" provision of medical care that is covered.
- Braces and other orthodontic appliances or services.
- Optometric services, eye exercises, and orthoptics, except for eye exams to determine the need for vision correction; eyeglasses or contact lenses except as specifically stated.
- Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness and/or astigmatism; contact lenses and eyeglasses required as a result of this surgery.
- Cosmetic surgery or other services solely for beautification or to improve appearance. Does not apply to reconstructive surgery to restore a bodily function or to correct a deformity caused by injury, or medically necessary surgery performed to restore symmetry incident to a mastectomy.
- Any procedures or treatments to change characteristics of the body to those of the opposite sex.
- Services primarily for weight reduction or treatment of obesity, except for treatment of morbid obesity determined by the plan or your medical group.
- Reversal of sterilization.

- Artificial insemination or in vitro fertilization procedures, and any related laboratory procedures; infertility treatment, family planning, or birth control services.
- Any services or supplies provided in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple.
- Treatment of any sexual dysfunction.
- Orthopedic shoes (except when joined to braces) or shoe inserts.
- Air purifiers, air conditioners, or humidifiers.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy; custodial care, rest cures, or treatment of chronic pain; services provided by a rest home, a home for the aged, a nursing home or any similar facility; services provided by a skilled nursing facility for custodial care.
- Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club, or gym, even if ordered by a physician.
- Any supplies for comfort, hygiene, or beautification.
- Food or nutritional supplements.
- Telephone consultations.
- Immunizations for foreign travel.
- Acupressure or massage to control pain, treat illness, or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points.
- Rehabilitative care, such as physical therapy, occupational therapy, or speech therapy, following illness or injury, unless provided by a home health agency, visiting nurse association or hospice.
- Non-prescription, over-the-counter patent or proprietary drugs or medicines; cosmetics, dietary supplements, health or beauty aids. Outpatient prescription drugs or medications and insulin are covered under the Blue Cross pharmacy plan.
- Contraceptive devices prescribed for birth control.
- Routine physical or psychological examinations or tests required by employment or government authority, or at the request of a third party such as school, camp, or sport affiliated organization; any other routine physical or psychological examination or test which does not directly treat an actual illness, injury, or condition.

UCSD MEDICAL CENTER - HOUSE STAFF MEDICAL PLANS SUMMARY

TYPE OF PLAN	BLUE CROSS PRUDENT BUYER PPO			BLUE CROSS CALIFORNIACARE HMO
	TIER 1	TIER 2	TIER 3	
CHOICE OF PHYSICIAN <i>See page 9 for CHSD Tier 1 providers</i>	UCSD/CHSD Receive services at UCSD Medical Center and CHSD	PPO Provider Any contracted Prudent Buyer Physician, lab, x-ray facility, or hospital	Non-PPO Any non-Prudent Buyer contracted physician, lab, x-ray facility, or hospital	Participating physicians and hospitals. Care must be directed by the primary care physician (PCP) to be eligible
Annual Medical Deductible Individual Family	No deductible No deductible	\$200 \$400	\$200 \$400	None None
Annual Out-of-Pocket Max. Individual Family	N/A N/A	\$1,000 N/A	\$2,000 N/A	\$1,000 – single \$2,000 – 2 person \$3,000 - family
Lifetime Max. Coverage Medical	Unlimited	Unlimited	Unlimited	Unlimited
Hospitalization Room and board ⁽¹⁾ w/ pre-admit certification w/o pre-admit certification Outpatient surgery Anesthesiologist Medical service and supply Durable medical equipment Intensive care unit	100% semiprivate 100% semiprivate 100% 100% 100% N/A 100%	80% semiprivate 80% semiprivate 80% 80% 80% 80% 80%	60% semiprivate 50% semiprivate 60% 60% 60% 60%	100% N/A N/A 100% 100% 100% 100% up to \$5,000/cal. yr 100%
Physician Services Office visits Routine physical exam (adult) Annual Pap smear Children – under age 17 Exams and inoculations All other services ⁽³⁾	\$10 co-pay, then 100% \$10 co-pay, then 100% up to \$250 100% 100% 100%	\$10 co-pay, then 100% Not covered 100% 100% 80%	60% Not Covered 100% 100% 60%	\$5 co-pay \$5 co-pay \$5 co-pay \$5 co-pay 100%
Mental Health or Substance Abuse Inpatient/partial hospitalization w/ pre-admit certification w/o pre-admit certification Mental health * Outpatient psychiatric care * <i>Severe mental health parity addressed on page 13</i>	100% 100%	80% 80%	60% 50%	\$100/day N/A N/A 30 days/cal. yr \$35 co-pay; 20 visits per 12-month period
Miscellaneous Prescription drugs ⁽⁴⁾ Maternity ⁽⁵⁾ Supplemental accident Home health care Skilled nursing facility	Generic \$12 co-pay Brand \$12 co-pay, plus difference in cost of generic & brand; \$18 co-pay if no generic equivalent Mail order 90-day supply Generic \$25 co-pay; Brand \$35 co-pay			Generic: \$5 co-pay Brand: \$10 co-pay <i>Mail order 90-day supply same co-pay as noted above</i> \$5 co-pay N/A \$5 co-pay; 100 days/yr max. 100%; 100 days/yr max
Hospice Care ⁽²⁾	N/A	80%; \$3,000/30-day lifetime max.		100%
Emergency Care Ambulance ⁽²⁾	100% after \$50 co-pay, waived if admitted N/A	80% after \$50 co-pay, waived if admitted 80%	60% after \$50 co-pay, waived if admitted 80%	\$100 co-pay, waived if admitted (48 hr notification required) 100%
Pre-existing Conditions Limitation	Waived only for maternity or mental health conditions	Waived only for maternity or mental health conditions	Waived only for maternity or mental health conditions	Waived for all conditions

1. To receive maximum benefit, authorized pre-certification is required per inpatient admission. To initiate pre-certification, call 1-800-274-7767.
2. Under the Blue Cross plan at this time a PPO is either not available or not being utilized for this type of service. Benefits will be paid as noted above.
3. All other services includes physical therapy, x-ray, and lab. In the PPO and HMO, short-term rehab (occupational, speech, and physical therapy) is limited to 60 days per illness/injury with a \$5 co-pay just in the HMO.

4. In the HMO plan, a 90-day supply of maintenance drugs is available at the \$10 co-pay through the mail order drug service. Oral contraceptives are available through the pharmacy benefit under both the PPO and HMO plans.
5. In both the PPO and HMO plans, a prenatal education program is offered to identify high risk pregnancies and lessen the chances of low birthweight babies. To enroll in the prenatal education program, call 1-800-769-4896.

DENTAL PLAN

Dental coverage is provided by Standard Pro-Dent. You may use the services of either a dentist participating in the Standard/Ameritas PPO or a dentist who does not participate in the PPO. The PPO is through Ameritas, an extensive network of participating dentists.

DEDUCTIBLE

There is no deductible for covered preventive services provided by an Ameritas dentist.

For all other covered dental services, per calendar year:

\$50 individual

\$150 family maximum (three members must satisfy \$50 each to equal \$150 total)

ANNUAL BENEFIT MAXIMUM

\$1,000 per person

SCHEDULE OF BENEFITS

	Ameritas Dentist	Non-Ameritas Dentist
Preventative Services	100%	80%
Routine oral exams, each 5 months		
Cleaning, each 5 months		
X-rays		
Full mouth x-rays or panoramic x-rays, each 3 years		
Bitewing x-rays, each 5 months		
Periapical x-rays		
Occlusal x-rays, each 2 years		
Fluoride treatment,		
For children 16 years or younger		
Sealants, limited to:		
■ Children 16 years of age or younger		
■ Posterior teeth only		
■ One application each 3 years		
Space maintainers		
Emergency office treatment for pain relief		
Basic Services	80%	60%
Fillings		
Simple extractions		
Basic periodontics		
Oral surgery		
Endodontics		
Repair of prosthetic appliances		
Recementing inlays, onlays, and crowns		
Major Services	50%	40%
Major periodontics		
Bridges		

Dentures
Crowns
Gold restorations
Replacement of damaged appliances

Orthodontic Services

If an Ameritas dentist is used:

- \$50 lifetime benefit is payable per dependent child
- The treatment fee is based upon a reduced negotiated fee instead of a usual, reasonable, and customary fee

EXCLUSIONS AND LIMITATIONS

Standard does not cover:

- Charges in excess of the reasonable and customary charge for the services or supplies provided, or which exceed the reasonable and customary charges for the least costly plan of the treatment when there is more than one accepted method of treatment for a dental condition.
- Charges for services or supplies which, in Standard's judgment, do not have a reasonable prognosis or which are not necessary according to accepted standards of dental practice.
- Charges for services or supplies which are not generally accepted by the dental profession and are, in Standard's judgment, experimental or investigational.
- Charges for services or supplies for which benefits are payable under any medical expense plan.
- Charges for services or supplies that are primarily for cosmetic purposes.
- Charges for implants, precision attachments or semi-precision attachments, acid etch (other than acid etch metal bridge retainers), instruction in dental plaque control or dental hygienics, or nutritional counseling.
- Charges for appliances or restorations to increase the vertical dimension or to restore the occlusion, or for gnathologic of jaw movements and positions.
- Charges for services or supplies related to diagnosis or treatment of the temporomandibular joint.
- Charges for services or supplies for which you are entitled to benefits under any Workers' Compensation law or employer's liability law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an accidental bodily injury or sickness arising out of or in the course of any employment for wage or profit.
- Charges for services or supplies received as a result of any dental condition caused or contributed to by war or any act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
- Charges resulting from changing from one dentist to another while receiving treatment or from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.

- Charges for services or supplies other than covered dental expenses listed above, or charges for services or supplies for which no charge would be made in the absence of insurance and for which you are not legally obligated to pay.

VISION PLAN

Vision coverage is provided by VSP. The plan requires that you use VSP doctors in order to receive maximum benefits. If you choose to go to an out-of-network provider, you pay the full fee and the plan reimburses you according to a schedule of benefits.

The vision care plan covers only regular eye exams; it does not cover medical or surgical treatments.

CO-PAYMENT

Per person, per plan year: \$10 for exam, \$25 for materials

SCHEDULE OF BENEFITS

Covered Expense	VSP Doctor	Out-of-Network Provider
Eye exam	Covered in full once each 12 months	Reimbursed up to \$40 once each 12 months
Lenses	Covered in full; 1 pair each 12 months if needed	Reimbursed up to specified maximums based on type: single vision \$40 bifocals \$60 trifocals \$80 lenticular \$125 1 pair each 12 months of needed
Frames	VSP fully covers a wide selection of frames; 1 pair each 24 months if needed	Reimbursed up to \$45; 1 pair each 24 months if needed
Medically necessary contacts (see Contact lenses, page 26)	Covered in full once each 12 months	Reimbursed up to \$210 once each 12 months
Elective contacts (see Contact lenses, page 27)	Covered up to \$105 once each 12 months with a \$10 exam deductible but no deductible for materials. Allowance is applied toward contact fitting and contact lenses.	Reimbursed up to \$105 once each 12 months

CONTACT LENSES

If you choose contacts, you will not be eligible to receive lenses and frames during the same service period.

Medically necessary contact lenses are fully covered under the plan when a VSP doctor secures prior approval for the following conditions:

- Following cataract surgery

- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
- Certain conditions of Anisometropia
- Keratoconus

FRAMES

Your VSP benefit provides guaranteed savings whether you choose a frame that is covered in full or one that exceeds the plan allowance. If you choose a frame valued at more than the plan's allowance, the difference you'll pay is based on VSP's low, discounted member pricing. Have your doctor help you choose the best frame for you based on your VSP coverage.

DISCOUNTS

VSP doctors offer valuable savings including a 20% discount on noncovered pairs of prescription glasses (lenses and a frame). Services must be received within 12 months from the same VSP doctor who provided your last covered eye exam. You can also save 15% off the cost of your contact lens exam when you receive contact lens services from VSP. (This discount does not apply to the contact lenses).

USING A VSP DOCTOR

To obtain vision care under the plan:

- Call a VSP doctor for an appointment. Identify yourself as a VSP member, covered under the UCSD Medical Center House Staff Group Plan, and provide any requested identification.
- If you need assistance in locating a VSP doctor, call VSP Member Services at 800/877-7195.

After you schedule your appointment, the VSP doctor will contact VSP to verify your eligibility and plan coverage and obtain authorization for services and materials.

USING AN OUT-OF-NETWORK PROVIDER

Although more than 90% of VSP patients receive care from VSP doctors, you have the option of seeing an out-of-network provider. Services received from an out-of-network provider are subject to the same co-pays and time limits as services received from a VSP doctor. For out-of-network reimbursement, pay the entire bill when you receive services, then send the following information to VSP:

- An itemized receipt listing the services received
- The name, address, and phone number of the out-of-network provider
- The covered member's Social Security number or member identification number
- The covered member's name, phone number, and address
- The name of the group
- The patient's name, date of birth, phone number, and address

- The patient's relationship to the covered member (such as "self," "spouse," "child," "student," etc.)

Claims must be submitted to VSP within six months from your date of service. Please keep a copy of the information for your records and send the originals to the following address: **Vision Service Plan, Out-of-Network Provider Claims, P.O. Box 997100, Sacramento, CA 95899-7100.**

NOTE

The lens allowances for contacts provided by an out-of-network provider are for two lenses. If only one lens is needed, the allowance will be one-half the pair allowance.

The amounts shown are maximums. The actual amount to be paid to you in reimbursement will be the maximum shown in the schedule for services, the amount charged, or the amount usually charged by the provider to private patients, whichever is the least amount.

LIFE INSURANCE PLAN

Life insurance, underwritten by Standard Insurance Company (The Standard), is a group term plan paid for by UCSDMC that includes an accidental death and dismemberment (AD&D) benefit.

LIFE INSURANCE BENEFIT

In case of your death, the plan will pay \$50,000. If your death is accidental, the plan will pay \$100,000. The proceeds will be placed in an interest bearing checking account for the beneficiary, who has complete control of the account and may write checks as needed or for the full amount.

If you suffer a loss of sight or dismemberment, a benefit which is a percentage of your AD&D coverage amount will be paid to you in the form of an interest-bearing checking account.

REPATRIATION BENEFIT

If you die more than 200 miles from your primary place of residence, the plan will pay expenses incurred to transport your body to a mortuary near your primary place of residence, up to the lesser of \$5,000 or 10% of the amount of your life insurance.

AGE REDUCTIONS

Life and AD&D insurance amounts are reduced on and after age 65 to a percentage of the original amount, as follows:

Your Age	Percentage
60 through 69	65%
70 through 74	50%
75 or older	35%

CONTINUED COVERAGE DURING TOTAL DISABILITY

If you become totally disabled before your 60th birthday and you complete a six-month waiting period, your life insurance may be continued during your disability up to age 65. The Standard has the right to require periodic proof of your continuing total disability.

ACCELERATED BENEFIT

If you qualify for continued coverage during total disability, you may be eligible to receive up to 75% of your life insurance benefit early if you become terminally ill, have a life expectancy of less than 12 months, and meet other eligibility requirements. There are no restrictions on how this money may be spent. The amount paid to you under the accelerated benefit provision (plus an interest charge) will reduce the amount of life insurance paid upon your death.

PORTABILITY OF LIFE INSURANCE

You may buy portable group life insurance if your employment terminates while you are under age 65, provided you are not disabled and you have been insured under your employer's group life insurance program for at least 12 months on the date your employment terminates. You must apply and pay the first premium within 31 days after the date your insurance under the group policy ends.

CONVERSION TO AN INDIVIDUAL LIFE INSURANCE POLICY

If your life insurance ends or is reduced, you may be able to convert coverage to an individual life insurance policy without submitting a medical history statement (evidence of insurability), provided application for the individual policy is made within 31 days after insurance ends.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The amount of coverage for the accidental death and dismemberment (AD&D) benefit is the same as and in addition to the amount of your life insurance.

The plan will pay a percentage of the amount of your AD&D benefit if you suffer one of the losses specified below due to an accidental bodily injury.

Loss of	Percentage of AD&D Benefit
Life	100%
One hand, one foot, or sight of one eye	50%
Two or more of the above losses	100%

For the AD&D benefit to be payable, satisfactory written proof of loss must be provided; the accident must occur while you are insured under the group policy; the loss must occur within 365 days after the date of the accident; and the loss must be caused solely and directly by accidental bodily injuries and independently of all other causes. With respect to a hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, loss means entire and irrecoverable loss of sight.

ADDITIONAL AD&D BENEFITS

If you die as a result of an accident for which an AD&D benefit is payable, the following additional benefits may be paid:

SEAT BELT BENEFIT

If you die as a result of an automobile accident and The Standard receives proof that you were wearing an approved seat belt at the time of the accident, the plan will pay an extra benefit equal to the lesser of \$10,000 or the amount of AD&D insurance for which you were insured.

CAREER ADJUSTMENT BENEFIT

An additional benefit may be paid to your spouse if your spouse enters a professional or trade program for the purpose of obtaining employment or increasing earnings. Tuition expenses up to \$5,000 per year may be reimbursed, provided the expenses are incurred within 36 months following your death. The cumulative total reimbursement may not exceed \$10,000 or 25% of the amount of AD&D insurance for which you were insured, whichever is less.

CHILD CARE BENEFIT

An additional child care benefit may be paid to your spouse for your children under age 13. Child care expenses which are incurred as a result of your spouse's working, or training for work or increased earnings, may be reimbursed up to \$5,000 per year, provided the expenses are incurred within 36 months

following your death. The cumulative total reimbursement may not exceed \$10,000 or 25% of the amount of AD&D insurance for which you were insured, whichever is less.

HIGHER EDUCATION BENEFIT

An additional higher education benefit may be paid to your child(ren) if within 12 months after your death your child is registered and in full-time attendance at an accredited institution of higher education. Tuition expenses up to \$5,000 per year may be reimbursed, provided the expenses were incurred within 48 months following your death. The cumulative total reimbursement may not exceed \$20,000 or 25% of the amount of AD&D insurance for which you were insured, whichever is less.

EXCLUSIONS

No AD&D benefits will be paid for losses caused or contributed to by: war or act of war, whether declared or undeclared; suicide or other intentionally self-inflicted injury, while sane or insane; committing an assault or felony or active participation in a violent disorder or riot (except while performing your official duties); voluntary use or consumption of any poison, chemical compound, or drug (unless used in accordance with the direction of a physician); sickness or pregnancy existing at the time of the accident; heart attack or stroke; or medical or surgical treatment for any of the foregoing.

LONG TERM DISABILITY PLAN

Long term disability coverage, underwritten by Standard Insurance Company (The Standard) is a group long term disability plan paid for by UCSDMC.

ELIGIBILITY

Interns, residents, and fellows working 20 hours each week, or an average of 20 hours each week during the preceding 12 months.

PREMIUM CONTRIBUTIONS

UCSD pays the cost of coverage.

BENEFIT

- Monthly benefit: 60% of the first \$5,000 of your pre-disability earnings reduced by deductible income; maximum \$3,000
- Minimum benefit: \$100 or 15% of benefit, whichever is greater

BENEFIT WAITING PERIOD

Benefits become payable after you have been continuously disabled for 30 calendar days.

BENEFIT DURATION

Up to normal Social Security retirement age.

RETURN-TO-WORK INCENTIVES

WORK EARNINGS INTEGRATION

If you work while you are disabled, your work earnings will reduce your LTD benefit as follows:

- During the first 24 months, the LTD benefit will be reduced by work earnings which, when added to your LTD benefit, exceed 100% of your indexed pre-disability earnings.
- Thereafter, the LTD benefit will be reduced by 50% of your work earnings.

REHABILITATION INCENTIVE

Benefit is increased by 10% while participating in a rehabilitation plan.

REHABILITATIVE EXPENSES

While the house officer is participating in an approved rehab plan, the house officer may be reimbursed for some or all of the expenses incurred in connection with the plan, including: family care expenses, training and education expenses, job-related expenses, and job search expenses.

REASONABLE ACCOMMODATION EXPENSES

The plan reimburses any employer up to \$25,000 for accommodations made by employer to return the disabled house officer to work. Standard must preapprove the accommodation.

COST OF LIVING ADJUSTMENT (COLA)

For the first five years, benefits increase by the lesser of the CPI or 3% per year.

SURVIVOR BENEFIT

Upon death while benefits are payable, an amount equal to six times the unreduced LTD benefit will be paid to eligible survivors.

MENTAL DISORDER

Benefits limited to 24 months for each period of disability. This limitation does not apply if the house officer is hospital-confined for a mental disorder at the end of the 24 months.

Mental disorder does not include bipolar disorder, organic brain syndrome, and schizophrenia. These conditions are treated as any other disability.

DRUG/ALCOHOL ABUSE

Benefits limited to one period of disability, up to 24 months of benefits (or end of participation in a rehab program), during the house officer's lifetime for drug/alcohol abuse.

EXCLUSIONS

- Pre-existing condition exclusion: Until the house officer has been continuously insured for five days, and has been actively at work for at least one full day after the end of that five days, a pre-existing condition for which the house officer was treated within the 30 days prior to becoming insured is not covered (credit given for time insured under a prior plan).
 - No benefits paid for disability resulting from: war, participation in a riot, self-inflicted injury, committing a felony.
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DEFINITION OF DISABILITY

- *During the benefit waiting period and the next 24 months of disability:* House officer is disabled if unable to perform with reasonable continuity the material duties of his/her own occupation and suffers an earning loss of at least 20% of indexed pre-disability earnings. Benefits will end if the house officer is working in own or any other occupation and earning more than 80% of indexed pre-disability earnings.
- *Thereafter:* House officer is disabled if unable to perform the material duties of any occupation. Any occupation means work the house officer is able to perform and

expected to earn at least 60% of indexed predisability earnings in any occupation in the national economy within 12 months after return to work.

DEDUCTIBLE INCOME

The following amounts for which the house officer is eligible due to the disability are used to reduce the LTD benefit:

- 100% backdoor integration with sick leave and other salary continuation (not including vacation pay) paid by UCSD
- Workers' compensation and similar benefits
- Social Security (including amounts for spouse and children under 18)
- SDI
- Earnings included in pre-disability earnings which the house officer continues to receive after disability
- Other group insurance benefits
- Amounts received by compromise, settlement, or other method as a result of a claim for any of the above
- Unemployment compensation
- Third party recovery

CONVERSION

You may buy LTD conversion insurance if your insurance ends and you meet the following requirements:

- Your insurance ends for a reason other than termination or amendment of the group policy
- You were continuously insured under the UCSD group LTD plan for at least one year as of the date your insurance ended
- You are not disabled on the date your insurance ends
- You are a citizen or are residing in the USA or Canada
- You apply for the conversion insurance within 31 days after your insurance ends

The conversion LTD insurance becomes effective on the day after your insurance ends.

The maximum LTD conversion insurance benefit you may select is not greater than the LTD benefit payable if you had become disabled on the day before your insurance ended and you had no deductible income.

The maximum LTD conversion insurance benefit is reduced by deductible income. The certificate that Standard will issue to you when your LTD conversion insurance becomes effective will contain other provisions which will also differ from the group LTD policy:

- There is a 180-day elimination period when you wish to make a claim.

- The plan covers you in your own occupation as a physician for 24 months and after that in any occupation with a 60% earning test to age 65.
- There is no offset with other individual LTD insurance you may have.