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LOMA LINDA UNIVERSITY
STUDENT HEALTH PLAN
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INTRODUCTION

Dear Student,

This document has been prepared to provide information and answer your questions regarding the Loma Linda University Student Health Plan (the "Plan"). This serves as the Plan document and the summary plan description. This Plan is an LLU-sponsored, self-funded student health plan designed to provide direct payment or reimbursement of a broad range of medical, prescription drug and dental expenses for you and your eligible dependents. The Plan also provides comprehensive coverage for a variety of preventive services with no member co-payment.

This Plan is funded by both University and student contributions. It provides direct payment and reimbursement for hospital care, surgery, emergency care, prescription drugs, and more. However, there is a preferred provider structure, and pre-admission and other pre-authorization certification requirements, as well as Plan limitations, exclusions and other provisions that affect your coverage. Through this Plan, it is our goal to maintain comprehensive and affordable coverage that will provide both financial protection and access to excellent medical services when a student or eligible family member needs care.

Please carefully review this entire document so that you will develop a better understanding of this Plan. As you review this document, pay special attention to the Plan definitions, limitations and exclusions.

Contact the LLUH Department of Risk Management with any questions regarding your coverage or eligibility. Contact information for Risk Management is in section **III. B. Administration**.

Loma Linda University Administration

I. LOMA L1INDA UNIVERSITY
STUDENT HEALTH PLAN

A. What It Is

This Plan is a University-sponsored, self-funded student health plan. It is not a health insurance policy or a health maintenance organization ("HMO"). This is an excess or secondary medical Plan. This means that if you have coverage under any other medical plan or insurance policy, this Plan will only provide coverage after the other Plan coverage has been applied. If you have no other coverage, the Plan will pay according to the Schedule of Benefit, subject to all of the Plan limitations and exclusions.

This Plan will provide direct payment or reimbursement of certain medical, prescription drug and dental expenses for you and your enrolled dependents. Details of this coverage (i.e., payment or reimbursement of expenses) are explained on the following pages. Generally, to be eligible for payments or reimbursements under the provisions of the Plan, expenses must be incurred while coverage is in effect. Expenses incurred before your Plan coverage becomes effective or after your Plan coverage has terminated will not be covered. **All coverage under this Plan is provided on a secondary or excess basis.**

B. What It Does

The Plan covers usual, reasonable and customary charges for the covered medical services and supplies outlined in the following pages that meet *all* the following criteria:

- they are medically necessary for the diagnosis or treatment of an illness or injury, or are services provided in conjunction with a routine annual physical exam; and
- they represent a commonly accepted form of treatment for the patient's diagnosis; and
- they meet professionally recognized, national treatment and quality standards; and
- they are provided by professionals operating within their scope of license; and
- the severity of the patient's condition requires the level of service provided; and
- they are expenses that the covered person has a legal obligation to pay.

Some types of services that may not meet these criteria are as follows:

- in-patient hospital services that are provided to a patient who could be treated in an outpatient setting
- outpatient emergency services that are provided to a patient who does not have an emergency medical condition
- services that are provided under a pre-paid medical or dental plan contract (such as an HMO) when the covered person is not legally obligated to pay the charges
- procedures that have no proven value or are not commonly accepted as useful
- experimental or investigational medical procedures, drugs, services or supplies
- procedures that might be unnecessary if performed along with another procedure
- services or procedures that are not ordered by a physician treating the patient

- diagnostic procedures that are not related to the patient's specific condition
- diagnostic procedures that are not expected to provide additional information when they are repeated
- procedures that could be performed more efficiently or at a lower cost in another setting

The usual, reasonable and customary charges will be determined by the Plan Administrator.

The fact that a physician or provider prescribes, orders, recommends or approves a service or supply does not, of itself, make the service medically necessary or a covered service. The Plan Administrator is solely responsible for determining which services or supplies are medically necessary and determining the reasonable and customary charges that will be covered by the Plan.

SERVICES OUTSIDE OF THE UNITED STATES: Only emergency medical services will be covered outside of the U.S. Coverage will only be provided for the treatment of an emergency medical condition.

BENEFITS WHEN A PERSON CAUSES INJURY TO THE COVERED PERSON: The Plan's obligation to provide benefits is secondary to the responsibility of any individual, entity, organization, insurer or other person who causes injury or is otherwise responsible for paying for any portion of the health care received by you or any other covered person. Any payments made by the Plan where another person may be responsible for paying or reimbursing for the health care are conditional. (See section **VII. COVERAGE AVAILABLE FROM OTHER SOURCES, A. Third Party Liability, B. Motor Vehicle Insurance and D. Coordination of Benefits** for more information.)

II. ELIGIBILITY

A. Coverage For You

The State of California requires California residents and their dependents to obtain, and maintain, health coverage or pay a penalty, unless they qualify for an exemption. Enrolling in the LLU Student Health Plan is one way to meet this requirement. You may be eligible to get free or low-cost medical coverage through Medi-Cal regardless of immigration status. In addition, you may be eligible for free or low-cost coverage through Covered California. Visit Covered California at www.coveredca.com to learn about coverage options available for you and your dependents, and how to qualify for financial assistance with the cost of coverage.

If you are under age 26 years of age, you may be eligible for coverage as a dependent in a group health plan of your parent's employer or under your parent's individual market coverage. In addition, you may be eligible to buy individual health insurance directly from a health insurer or health plan, regardless of immigration status.

Please explore your options carefully to see if other options or more affordable and whether you are currently eligible to enroll in these other forms of coverage pursuant to an open enrollment or special enrollment period.

Student Health Plan coverage is included in the enrollment fee charged to LLU students. You are eligible for student health plan coverage in a quarter during which you are a registered student of Loma Linda University ("LLU") and you;

- are charged the enrollment fee, and
- have completed the enrollment process, and
- are participating in a degree program, or
- are participating in a non-degree program but are registered for more than 4 units, or
- are an "In Progress" IP student

B. Waiving Coverage

Students who have alternative creditable health coverage may choose not to enroll in the LLU Student Health Plan. If student does not want to enroll in the Plan, she/he will be asked to provide information regarding the other coverage and sign a waiver to confirm the student does not want to participate in the Plan. There will be no adjustment to the student fee for those students who choose not to enroll in the Plan.

C. Students Who Are Not Eligible for Coverage

The following categories of students are not eligible for the LLU Student Health Plan.

- Any student who drops all units within one week of the start of classes will receive a full refund of the enrollment fee and will not be eligible.

- Students who are working for a LLUH related entity and are full-time benefit eligible employee will not be charged the enrollment fee and will not be eligible for Student Health Plan coverage.

- Students who are participating in Off Campus or Online programs will not be charged the enrollment fee and will not be eligible for Student Health Plan coverage.

Note that there are other school specific fees that may be charged independent of the enrollment fee.

D. Coverage For Your Dependents

In addition to yourself, the following individuals are also eligible to be covered under the Plan as your dependents, but only if you are covered under the Plan;

1. Spouse

Your spouse who is living with you. A spouse who is a resident of the State of California who is not living with you may be covered:

- for up to six months during a trial separation; or

- for up to six months if you and your spouse live at separate locations

After the six-month period of separation, the spouse or student must notify the Plan Administrator of the spouse's change of address and the spouse is no longer eligible as a dependent under the Plan. A spouse who is not living with you at the time of enrollment may not enroll in the Plan unless the spouse joins your household and lives with you on a full-time basis. Note that your spouse is not eligible as a dependent if you are legally separated with an order of separation from a court or if you are divorced (see section **II. K. When Coverage Ends**).

2. Children

Any Child,

- who is born to you, or

- is legally adopted by you, or

- is a step-child (child of your spouse)

and who:

- is under age 26, or

- has never been married and is totally and permanently disabled (as defined by the Plan)

Child also includes a foster child as defined in IRS code section 152(f) and a child for whom the student is required to provide coverage pursuant to the terms of a qualified medical child support order "QMCSO". See section **VII. D. Coordination of Benefits** for additional information regarding children of divorced or legally separated parents.

No person may be covered under the Plan as a student and dependent or as a dependent of more than one student.

3. Adult Children with a Total Permanent Disability

If a child is totally and permanently disabled, is unmarried and is incapable of self-sustaining employment by reason of a permanent mental or physical disability that commenced before the child reached age 19, has been determined to be disabled by the Social Security Administration and is primarily dependent on the student parent for support and maintenance, the child's eligibility will be extended past attainment of age 26 for as long as the student parent is covered under the Plan and the child continues to qualify for coverage in all aspects other than age. The Plan may require you at any time to (i) obtain a physician's statement certifying the physical or mental disability and (ii) submit evidence of the Social Security Administration determination of disability.

E. Buy-in Provision

An eligible student may extend coverage to a spouse and/or children through the enrollment process each calendar quarter. To receive dependent coverage under the Plan a student must submit a completed enrollment form and pay the required dependent contribution by the first day of each quarter (January 1, April 1, July 1 and October 1) with coverage to apply for the following quarter. If a student experiences a family change such as marriage or new child, dependents must be enrolled within 30 days of this type of special enrollment event (see section **J. Special Enrollment** below) and pay the appropriate quarterly student contribution as outlined below:

Coverage for	Quarterly Contribution
Spouse of a covered student	$700
One or more children of a covered student	$420
Spouse and children of a covered student	$1,120
Student LOA or Continuation coverage	$535

The quarterly buy-in rates are subject to change. Payments may be made via check or credit card.

F. Leave of Absence (LOA)

Students on an approved leave of absence may extend the Student Health Plan coverage for up to one year, while on an approved leave. Students must complete an enrollment form and pay the quarterly contributions referenced above.

G. Enrollment

When you register as an LLU Student, in a degree track program you will also be asked to complete an on-line health plan enrollment process. To extend coverage to a spouse or dependent child, you must also complete and submit an enrollment form for your dependents. For more information or to obtain an enrollment form, contact the Department of Risk Management.

You may terminate coverage for your dependents at the end of any quarter but if you are no longer eligible to be covered under the Plan as a student, your dependents' coverage will automatically be terminated.

If a covered student or spouse gives birth while covered under the Plan, the newborn child will be automatically

covered for 30 days if the mother is covered under the Plan. However, a newborn child must be enrolled in the Plan within 30 days of birth to extend dependent coverage beyond this 30-day period. An adopted child must also be enrolled within 30 days of adoption. After enrolling, you will receive your Health Plan Identification Card.

In case of a special enrollment event, such as a change in family status (e.g., the birth of a child or a change in marital status) you may be permitted to make certain changes to your coverage under the Plan, provided you make such changes within 30 days of the occurrence of the special enrollment event or during an open enrollment period. Changes in family or eligibility status such as marriage, adoption of a child, or change in spouse's health care coverage may require written documentation to verify the change in status**.** (See section **J. Special Enrollment – Changes in Eligibility** for more information.)

You may terminate coverage for yourself or your dependents effective at the end of any quarter but if you terminate your own coverage, your dependents' coverage will automatically be terminated. Once terminated, you will not be able to re-enroll yourself or your dependents until a change in status or the beginning of the next quarter.

When applying for coverage under the Plan, it is necessary that accurate and complete information be provided. If relevant information is misstated, or not disclosed, coverage may be adjusted, as appropriate, based upon the correct information and you will be obligated to refund to the Plan any benefit payments incorrectly received.

H. When Coverage Begins

When you enroll in the Plan, your coverage will begin, as applicable:

- at the beginning of the school year on your first day of classes or student orientation whichever is first
- if you enroll within 30 days of a special enrollment event, coverage will begin on the date of a birth, adoption or placement for adoption or on the date your enrollment form is received for all other special enrollment events

I. Open Enrollment

Open enrollment is a period of time during which any eligible student may extend coverage to an eligible dependent. There is an open enrollment opportunity the last two weeks of each calendar quarter, with dependent coverage to become effective as of the first day of the quarter following. To extend coverage to a spouse or dependent child, a student must complete and submit an enrollment form and make payment to the Department of Risk Management before the first day of the calendar quarter.

J. Special Enrollment - Changes in Eligibility

If your family members are eligible for participation in the Plan but do not enroll because such family members have other group coverage, or if you gain a new eligible family member (e.g., through marriage, birth or adoption), you may enroll outside of open enrollment if you or your family members experience a special enrollment event (such as a change in family or eligibility status). You may also be eligible to change an election upon the occurrence of a special enrollment event. To make or change an election on account of a special enrollment event, any change(s) in family or eligibility status must be reported to the Risk Management Department within 30 days of the occurrence of such event. **If you want to obtain coverage under the Plan following a change in your family status, you must apply for coverage within this 30-day special enrollment period or your dependents will not be eligible for coverage until the next open enrollment period.** The following events are "special enrollment events" which allow you to elect coverage under the Plan but only to the extent the election or change in election is both on account of and consistent with the event:

- a change in your legal marital status (due to a marriage, divorce, annulment, legal separation or death of spouse)
- a legal change in a domestic partnership

- a change in the number of your dependents (due to a birth, death, adoption or placement for adoption)
- any of the following events that change the employment status of your spouse or your dependents: a termination or commencement of employment, a strike or lockout, a change in worksite or other changes in employment status which affects the person's eligibility for benefits under a group health plan of the person's employer
- a change in the place of residence for you, your spouse or your dependents
- a loss of health coverage under another plan or an exhaustion of COBRA continuation coverage under another plan, but only if such coverage was in effect when coverage under the Plan was previously declined (and, in the case of loss of health coverage under another plan, such loss occurred due to a loss of eligibility for the coverage), or if employer contributions to such coverage were terminated, in any case that results in the commencement of a special enrollment period under the Health Insurance Portability and Accountability Act of 1996, as set forth in section 9801(f) of the Internal Revenue Code
- the entry of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for your child; provided, however, that if the judgment, decree or order requires another person to provide the coverage, you may cancel the coverage only if the coverage is in fact provided by the other person
- you, your spouse or your dependent becomes entitled to coverage under Part A or Part B of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act (other than coverage consisting solely of the distribution of pediatric vaccines)
- loss of eligibility under Medicaid (MediCal) or a state Child Health Insurance Program (CHIP). If you or an eligible dependent is covered under a Medicaid plan or state CHIP plan, and that coverage is terminated because you are no longer eligible, then you and your eligible dependent may enroll in the Plan if you are otherwise eligible for coverage

K. When Coverage Ends (also see section **L. Continuation of Coverage** below**)**

Your coverage under the Plan ends on the last day of the quarter

- during which you stop meeting eligibility requirements

For your dependents, coverage ends on the earlier of the last day of the quarter:

- during which you stop meeting eligibility requirements, or
- during which you fail to make a required quarterly contribution for the following quarter, or
- during which your dependents last meet eligibility requirements

In addition, for your spouse, coverage would also end on the earlier of when there is an order for legal separation from your spouse, when you are divorced from your spouse or when your marriage is annulled. Also, your spouse will not remain eligible for coverage under this Plan if your spouse has not lived with you for six months. **Students are required to notify the Risk Management Department and/or the Plan Administrator of a divorce, legal separation or annulment or change of spouse's residence within 30 days of the event.**

In addition, for your children, coverage also ends when they cease to be an eligible dependent under the Plan. See section **II. D. Coverage for Your Dependents** and section **VII. D. Coordination of Benefits** for additional information regarding children of divorced or legally separated parents.

L. Continuation of Coverage

A student may no longer meet the eligibility criteria for coverage as an active LLU student under the following

circumstances:

- the student's academic program includes a summer break when the student is not registered for classes
- the student graduates from his/her program
- the student does not reenroll during a quarter
- the student drops his/her classes during the first 10 days of the quarter and receives a refund of tuition and fees

Under these circumstances, the student and any covered dependents may extend the Plan coverage for one additional quarter by submitting an enrollment form and paying the quarterly contributions referenced in section **II. E. Buy-in Provision**. The enrollment form and payment must be received by the Department of Risk Management within 10 days of the beginning of the quarter during which the student no longer meets the eligibility criteria for an active student.

III. ADMINISTRATION

A. Plan Administration

The Loma Linda University Health ("LLUH") Department of Risk Management administers this Plan. Risk Management will oversee the program, receive, review, and pay the claims presented in accordance with the provisions of the Plan and will answer any questions regarding your coverage. As the Plan Administrator, Risk Management has the sole discretion and authority to interpret the language of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Direct payment or reimbursement will be provided under the Plan only upon a determination made by Risk Management in its sole discretion. LLU and the Plan Administrator has the right to amend, modify or terminate the Plan in any manner, at any time and from time to time. The Plan Administrator may also change or replace this Plan document at any time, without the consent of any Plan member. The Plan Administrator may hire others to perform claims processing and other specified services in relation to the Plan and may designate any person, partnership, corporation or committee to carry out any of its responsibilities. The Plan Administrator's contact information is included below under section **III. B. Claims Processing Procedures**. Risk Management may designate any person, partnership, corporation or committee to carry out any of its responsibilities with respect to the Plan (in each case irrespective of whether such responsibilities are fiduciary or settlor in nature).

The LLU Student Health Plan Appeals Committee has the discretion and authority to interpret the language of the Plan and to determine eligibility for Coverage under the Plan in response to any Level 2 appeals.

All determinations and actions of the Plan Administrator shall be conclusive and binding upon all affected parties except for a decision that is overruled under the Level 2 or External Appeals process.

B. Claims Processing Procedures

All claims for benefits (including any pre-authorization, direct payment or reimbursement) will be processed through Risk Management and should be submitted to:

Loma Linda University Health
Department of Risk Management
197 E. Caroline Street
San Bernardino, CA 92408
(909) 651-4010 or extension 14010

There is a maximum fee upon which your benefit payments will be calculated. The maximum fee is the reasonable and customary charge as determined by Risk Management. (See section **VIII. C. How to Make a Claim**).

C. Statute of Limitations for Actions under the Plan

No legal or equitable action relating to a claim may be commenced later than one (1) year after the claimant receives a final decision in response to the claimant's request for review of the adverse benefit determination in accordance with the claims procedure as described in section **VIII.** and (b) no other legal or equitable action involving this Plan may be commenced later than two (2) years after the date the person bringing the action knew, or had reason to know, of the circumstances giving rise to the action. This provision shall not bar this Plan or its representatives from recovering overpayments or other amounts incorrectly paid to any person under this Plan at any time or bringing any legal or equitable action against any party.

D. Applicable Law and Venue.

This Plan and all rights hereunder shall be governed by and construed in accordance with the laws of the State of California without regard to conflicts of law to the extent such laws have not been preempted by any applicable federal law. Any action involving this Plan (legal or equitable) that is brought by any enrollee or any other person shall be litigated in the courts located in the State of California and no other federal or state court. The claims procedures set forth in section **VIII.** must be exhausted prior to any enrollee or any other person bringing an action under this Plan.

IV. MEDICAL COVERAGE

This section describes the medical coverage available under the Plan. Any coverage is subject to the limitations, exclusions, required authorizations and/or co-payments listed below or in section **XIV. Schedule of Benefits** or otherwise set forth in the Plan.

A. Student Health Service

Students and eligible dependents enrolled in the Student Health Plan can receive basic primary care services at no cost at the Student Health Clinic located at the Center for Health Promotion. Students can schedule an appointment at Student Health or simply walk-in to the clinic to receive services during walk-in hours. Services include physical exams, immunizations, laboratory testing, etc. The Student Health Center will also facilitate referrals for patients who need specialty care.

The Center for Health Promotion also operates an international travel clinic on site. This clinic can provide medical advice, counseling and immunizations to anyone traveling outside of the U.S.

The Student Health Clinic is located at the center of the LLU campus at 247785 Stewart Street, Evans Hall, Suite 111, Loma Linda, CA 92354. The clinic appointment hours are from 8:00 am to 12:00 pm and 1:00 pm to 5:00 pm Monday through Thursday and from 8:00 am to 1:00 pm on Friday. Walk-in times are from 8:00 am to 11:30 am and 1:00 pm to 4:30 pm Monday through Thursday and from 8:00 am to 12:30 pm on Friday. To schedule an appointment, call (909) 558-8700 or extension 88700.

B. Preferred Providers

To reduce costs, the Plan has a "preferred provider" relationship with Loma Linda University Medical Center, Loma Linda University Children's Hospital, Loma Linda University Behavioral Medicine Center, Loma Linda University Medical Center-Murrieta and the other health care providers listed in the Preferred Provider Directory**.** This directory includes all the Plan preferred providers along with their telephone numbers and addresses.

These hospitals, physicians and other health care providers offer covered Plan members discounts from their regular inpatient and outpatient charges. By accessing these hospitals and physicians, students can reduce their out-of-pocket costs and the cost to the Plan. Because of the increased costs resulting from student utilization of non-contracted, out-of-network providers, members will be required to pay a higher co-insurance percentage for services provided by any other hospitals, physicians and health care providers. However, these increased co-payments will

not be applied if a student or dependent requires out of area emergency services for the treatment of an Emergency Medical Condition (see section **XIII. Definitions**) or if required services are not offered by any preferred provider, or contracted facility and are authorized by the Plan Administrator. If the covered patient's medical condition does not require treatment for an Emergency Medical Condition, and the services are not authorized to be provided out-of-network, the higher out-of-network co-insurance will apply. Any condition that does not require hospital emergency medical treatment should be treated at a physician's office or Urgent Care center.

Non-emergency services, outside of the preferred provider network, will only be paid at the higher preferred provider rate if Risk Management specifically authorizes these services. In rare instances, the contracted preferred provider physicians may refuse to provide services to a patient because the patient's actions, lack of cooperation or misconduct has compromised an effective physician/patient relationship. Under these circumstances, the patient may obtain out-of-network services but the higher non-preferred provider co-insurance will apply.

C. Out-of-Pocket Maximum

Co-insurance percentages and co-payments represent the portions of covered service expenses paid by you. These percentages apply only to covered service expenses that do not exceed reasonable and customary charges. You are responsible for all non-covered service expenses and any amount that exceeds the reasonable and customary charge for covered service expenses. Note that preferred providers have agreed to accept the reasonable and customary allowance as determined by Risk Management. These providers will not balance bill patients for any amounts above this allowance when the services are covered by the Plan.

Your out-of-pocket aggregate co-payments and co-insurance for most preferred provider medical services covered under the Plan are limited to annual maximum of $3,500 per individual and $7,000 per family. **However, any co-payments and co-insurance to an out-of-network provider, co-payments or co-insurance for prescription drugs, co-insurance and deductibles for orthotics, prosthetics, and any additional co-insurance for failure to obtain pre-admission authorization, charges above the reasonable and customary limit, or any other non-covered expenses do not apply toward the individual out-of-pocket maximum. In addition, these services are not subject to the maximum out-of-pocket limit**. The Plan also includes separate annual out-of-pocket maximums of $3,500 per individual and $7,000 per family for prescription drug co-payments. (see section **IV. M. Prescription Drugs**).

D. Hospitalization and Surgery

1. Pre-Admission Review

Pre-Admission Review is a screening process that takes place when a doctor recommends hospitalization or surgery for a student or a covered dependent. This process involves evaluating the proposed admission on an individual basis to determine the need for admission to an acute care hospital or to discuss other care options that may exist for treatment of the condition, including having the condition treated in a doctor's office, outpatient facility, ambulatory/surgical setting, home environment with medical support or other appropriate settings.

Members in the Plan benefit from pre-admission review since this process confirms the medical necessity of a proposed hospitalization or surgery and promotes quality health care in the most cost efficient manner. This service is provided by the Plan with no cost to members.

Members in the Plan must follow the pre-admission review process in order to receive full hospitalization benefits. **IF A MEMBER DOES NOT FOLLOW THE PRE-ADMISSION REVIEW PROCESS, HOSPITALIZATION AND SURGERY BENEFITS WILL BE REDUCED BY 50%.** It is the ultimate responsibility of the student to make sure that the review process has been followed. All non-emergency admissions <u>must</u> be reviewed and authorized prior to entering the hospital. When a doctor recommends hospitalization, the following steps should be followed:

a. Tell your doctor that your health plan requires pre-admission review on proposed hospital admissions or surgery and that the Case Manager at the LLUH Department of Risk Management will perform this service.

b. You should ask your doctor to contact Risk Management 10 days prior to the proposed admission. If your doctor recommends hospitalization in less than 10 days, you, or your doctor's office, must immediately call Risk Management at 909/651-4010 or extension 14010 Monday through Thursday, 8:00 a.m. - 5:00 p.m., Friday 8:00 a.m. - 2:00 p.m.

c. Based on the information provided, Risk Management will evaluate the medical necessity of the planned admission and discuss the case with your physician if necessary. Your doctor will be notified regarding the authorization for hospitalization or surgery.

d. Upon entering the hospital for an authorized admission, show your Health Plan Identification Card to the hospital admitting office. While hospitalized, Risk Management will communicate with hospital staff regarding your progress and discuss additional or alternative care as indicated.

Risk Management will discuss all medical necessity decisions with your doctor. Normally, an agreement can be reached between Risk Management's physician advisors and your doctor as to an alternative treatment plan for your condition if Risk Management determines that medical necessity does not exist for hospitalization or surgery. If, however, agreement is not reached between Risk Management and your doctor, the option of entering the hospital remains your decision. However, you may not be eligible for benefits for such services payable as detailed in the Plan. If you wish to appeal the pre-admission review decision, refer to section **VIII. (F) How to File an Appeal.**

2. Emergency Admissions

In the case of an emergency, follow your doctor's advice and seek appropriate medical care. If emergency hospitalization occurs, you, your doctor, or a family member must notify Risk Management within 48 hours or, if later, on the next business day after admission to obtain an authorization for continued hospitalization. **NOTE: Emergency Services will only be covered if the patient's condition requires treatment for an Emergency Medical Condition as defined by the Plan. If a patient's condition is not an Emergency Medical Condition (as defined by the Plan) and the patient obtains services at an out-of-network hospital, the patient will be responsible for 75% co-insurance.**

3. Covered Services and Expenses

Acute care hospitalization is covered only when medically necessary. If services are provided by a preferred provider, coverage is provided with no member out-of-pocket expenses for approved inpatient care or outpatient surgery. **If any other hospital or physician (out-of-network provider) provides services, the Plan will only pay 25% of the allowable charges and members will be responsible for 75% co-insurance.**

This applies to the following areas:

- semi-private room
- miscellaneous acute care hospital expenses
- inpatient surgical and anesthesia charges
- outpatient surgery charges for authorized procedures requiring general, spinal or nerve block anesthesia
- reasonable and customary inpatient physician fees

4. Outpatient Surgery

The Plan will cover outpatient surgical procedures requiring general, spinal or nerve block anesthesia the same as inpatient hospital services. However, the procedure must be authorized in advance by the Risk Management Case Manager and must be performed in an approved Outpatient Surgical Facility.

If a physician office or other facility does not qualify as an Outpatient Surgical Facility, or if the surgical procedure does not require the use of an Outpatient Surgical Facility, any professional surgical charges may be covered as regular outpatient medical services but surgical facility charges will not be covered.

5. Partial Hospitalization

Partial hospital programs provided by an acute care facility for the treatment of mental illness or drug or alcohol rehabilitation may be covered on the same basis as inpatient psychiatric services if the services are authorized in advance by Risk Management.

6. Skilled Nursing

The Plan will provide up to 60 days of coverage per plan year for skilled professional care provided in a licensed skilled nursing facility following an acute care hospitalization. However, services must be authorized in advance by Risk Management. In order for coverage to be authorized the patient's medical condition:

- must require skilled nursing services or skilled rehabilitation services, and
- must require these services on a daily basis, and
- will not allow these services to be provided on an outpatient basis

If any of these criteria is not met, services provided in a Skilled Nursing Facility will not be covered under the Plan.

7. Limitations:

- coverage for cosmetic procedures is limited to reconstruction necessary due to illness, injuries or congenital birth defects sustained by an individual while covered by the Plan
- hospitalization or surgery without required pre-admission authorization will be subject to a 50% reduction in coverage
- inpatient hospital expenses for services that are not provided by a preferred provider will be subject to higher co-insurance (see section **XIV. Schedule of Benefits**)
- only emergency medical services will be covered outside of the United States
- skilled nursing facility services must meet the Plan criteria and must be authorized in advance
- Emergency Services will only be covered if the patient is being treated for an Emergency Medical Condition as defined by the Plan

8. Exclusions:

- any charges or expenses related to or resulting from surrogacy
- convalescent hospital care, nursing home care, residential care of any kind, respite care, adult day health care, homemaker services, special day care, continuing care retirement facilities and assisted living facilities
- custodial care
- elective abortions

- expenses the covered person does not have a legal obligation to pay or services provided to the covered person under a pre-paid medical or dental plan such as a Health Maintenance Organization (HMO)
- experimental or investigational medical procedures, treatment, drugs, services or supplies
- infertility diagnosis and treatment
- obesity or weight management surgery and/or any related services or treatment, including complications from obesity treatment
- personal convenience items (including clothing of any kind)
- refractive eye surgery, laser vision correction or any other medical treatment or procedures intended to improve the refraction character of the eye
- removal of cosmetic breast implants or the treatment of any medical complications related to cosmetic breast implants
- residential treatment programs
- reversal of voluntary or surgically induced infertility or the treatment of infertility following such a procedure
- reversals or revisions of any procedures which are intended to alter the refractive character of the eye and any related complications from these procedures
- services and facilities provided by or in a hospital owned or operated by a federal government or any agency thereof for a disability related to military service
- services that are not medically necessary for the diagnosis or treatment of an illness or injury
- sub-acute or residential inpatient care
- treatment of calluses, corns, or toenails by surgical incision, except for the removal of nail roots or the treatment of foot related vascular or metabolic disorders unless the patient's underlying medical condition requires such treatment
- treatment rendered outside of the United States (except for medical emergencies)
- treatment of a work-related illness or injury

E. Obstetrics

1. Covered Services and Expenses

Under the Plan, pregnancy-related expenses are generally covered in the same way as other medical expenses for illness or injury. Charges incurred before your coverage is effective or after your coverage terminates will not be covered.

Professional obstetrical services for childbirth are subject to a flat co-payment of $400 per delivery if a preferred physician provider renders these services. Additional co-payments will apply to other professional medical services that are not included in the delivery charge.

2. Limitations:

- services that are not provided by a preferred provider will be covered subject to higher co-insurance (see section **XIV. Schedule of Benefits**)

- breastfeeding equipment and associated supplies are covered up to a $500 limit

3. Exclusions:

- any charges or expenses related to or resulting from surrogacy

- any facility or supply charges from a birthing center or related to a home delivery

- charges for missed or broken appointments

- elective abortions

- expenses the covered person does not have a legal obligation to pay, or services provided to the covered person under a pre-paid medical plan such as an HMO

- experimental or investigational medical procedures, treatment, drugs, services or supplies

- infertility diagnosis and treatment

- prenatal classes and parent training courses

- reversal of voluntary or surgically induced infertility or the treatment of infertility following such a procedure

F. Outpatient Medical Services

1. Covered Services and Expenses

For coverage to apply, medical services must be rendered by licensed health care professionals operating within the scope of their license. Medical services, testing or x-rays must be ordered by a treating physician and be directly related to a documented diagnosis or complaint, or be provided in conjunction with a routine physical exam.

The following outpatient services are covered subject to any co-payments, co-insurance or limitations set forth below or in section **XIV. Schedule of Benefits.**

- physician office visits

- home care services

- lab and x-ray

- non-surgical medical services and testing

- surgical procedures

2. Preventive Services

Preventive services provided by a preferred provider are covered at 100% with no student co-payment. Preventive services include:

- an annual preventive physical exam
- administration of medically indicated vaccines
- well baby checkups
- breastfeeding equipment and supplies (subject to limitations) for the covered mother of a newborn child.

3. **Limitations:**

- home care services are subject to an annual limit of 60 visits per plan year and will only be covered if the patient cannot be transported to an outpatient treatment facility (home care must be approved in advance by Risk Management)
- formula is only covered when it is prescribed by a physician as a medically necessary component of medical treatment due to a patient's inability to consume food and is authorized in advance by Risk Management.
- professional services that are not provided by a preferred provider will be covered subject to higher co-insurance (see section **XIV. Schedule of Benefits**)

4. Exclusions:

- acupuncture services
- any charges or expenses related to or resulting from surrogacy
- charges for missed or broken appointments
- custodial care
- diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues
- expenses the covered person does not have a legal obligation to pay, or services provided to the covered person under a pre-paid medical or dental plan such as an HMO
- experimental or investigational medical procedures, treatment, drugs, services or supplies
- first aid supplies
- infertility diagnosis and treatment
- obesity management, surgery and/or any related services or treatment, including complications from obesity services or treatment
- dental services (see section **V. Dental Coverage**)
- physical examinations or testing for the purposes of licensing, insurance, employment, immigration or other non-preventive purposes
- private duty nursing

- refractive eye surgery
- residential treatment programs
- services or supplies not certified as necessary by a licensed health care professional and/or physician
- services that are not medically necessary for the diagnosis or treatment of an illness or injury (except for services provided in conjunction with a routine physical exam)
- special charges for services rendered after normal office hours or on weekends
- the removal of cosmetic breast implants or the treatment of any medical complications related to cosmetic breast implants
- treatment of a work-related illness or injury

G. Outpatient Health-Related Services

1. Covered Services and Expenses:

- medical supplies
- occupational therapy
- physical therapy
- prosthetics and orthotics
- rental of durable medical equipment for 90 days (rental cost may be applied toward purchase, subject to prior authorization from Risk Management)
- speech therapy

2. Limitations:

- breastfeeding equipment and supplies purchased in conjunction with the pump are covered up to an annual maximum limit of $500 (see section **XIV. Schedule of Benefits)**
- formula may only be covered when it is prescribed by a physician, is medically necessary as a component of medical treatment, is due to a patient's inability to consume food and is authorized in advance by Risk Management
- medical supplies will only be covered if they are provided in conjunction with authorized home care or hospice services or if the supplies are required for the use of medical equipment or in follow up to treatment or procedures that were covered by the Plan (requires prior authorization from Risk Management, (see section **XIV. Schedule of Benefits**)
- prosthetics and orthotics are only covered, repaired or replaced based on medical necessity (with prior authorization from Risk Management) and are subject to an annual maximum limit, (see section **XIV. Schedule of Benefits)**
- physical, occupational and speech therapy will only be covered if it is medically necessary, ordered by a physician, provided by a licensed therapist and can be expected to result in significant functional improvement of a member's condition within a period of sixty (60) days. Coverage for therapy requires

prior authorization from Risk Management. Physical, occupational and speech therapy is also limited to a maximum treatment period of one year, following an injury or diagnosis of an illness or condition(s)

- rental of medically necessary equipment such as wheelchairs, walkers, traction equipment, crutches, etc., will only be covered for a maximum of 90 days (rental cost may be applied toward purchase, with prior authorization from Risk Management)

- services that are not provided by a preferred provider will be covered subject to 75% co-insurance (see section **XIV. Schedule of Benefits**)

- there is no coverage allowed for insulin pumps until a person has been covered under the Plan for one year

3. Exclusions:

- acupuncture services

- biofeedback

- care and/or treatment for hair loss, including hair transplants, toupees, wigs, or drugs used for hair growth

- charges for missed or broken appointments

- chiropractic services

- custodial care

- exercise or fitness equipment

- first aid supplies

- hypnosis

- massage services unless provided by a licensed therapist in conjunction with authorized physical or occupational therapy

- nutritional supplements and vitamins

- obesity management, surgery and/or any related services or treatment, including complications from obesity services or treatment

- dental services (see section **V. Dental Coverage**)

- physical examinations or testing for the purposes of licensing, insurance, employment, immigration or other non-preventive purposes

- personal convenience items (including clothing of any kind)

- private duty nursing

- refractive eye surgery

- reversals or revisions of any procedures which are intended to alter the refractive character of the eye and any related complications from these procedures

- repair of any durable medical equipment
- replacement or duplication of any durable medical equipment that is still functional
- sales tax or charges for shipping and handling
- services provided by or ordered by the patient or a person who ordinarily resides in the home of a patient or an immediate family member
- services that are not medically necessary for the diagnosis or treatment of an illness or injury (except for services provided in conjunction with a routine physical exam)
- social worker visitation or consultation
- special shoes or other devices or appliances for the treatment of bunions, corns, calluses, toenails or similar conditions of the feet
- transportation expenses (other than ambulance)
- treatment for learning disabilities or developmental delay
- treatment of a work-related illness or injury

H. Hospice Care

1. Covered Services and Expenses

Hospice is an alternative to hospitalization for the treatment of terminally ill patients. It is a coordinated program of home care and support services designed to improve the quality of life for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs due to physical, psychological, spiritual, social, and economic stresses often experienced during the final stages of illness, dying and bereavement.
A "terminally ill patient" is someone who has a life expectancy of approximately six (6) months or less, as certified by the physician in charge of the patient's care and treatment. The Plan will pay allowable covered charges for:

- services of physicians, nurses, home health aides, therapists, chaplains and social workers
- health care services at home, including use of medical equipment and rental of wheelchairs and hospital-type beds
- psychological support services and physical and chemical therapies

2. Prior Authorization

Prior approval must be obtained through Risk Management before hospice services are initiated.

3. Limitations:

- only those services provided by a qualified hospice program that meets the standards of the National Hospice Organization (NHO) and applicable state licensing requirements will be covered

I. Outpatient Psychiatric Services/Counseling

1. Student Counseling Services

All students have access to free confidential student counseling services through the Student Assistance Program. This program is staffed by licensed marriage and family therapists who can help students work through a variety of personal issues and challenges. Students may access services and receive support for stress, test anxiety, depression, relational issues, addiction, anger management, personal adjustment to academic life, identity issues, etc. Therapists are available for crisis intervention, individual therapy, couples therapy and premarital therapy. The Student Assistance Program provides up to10 visits/year and can offer referrals to community therapists for long-term therapy support. There are no co-payments for the services provided at the Student Assistance Program.

The Student Assistance Program is open from 8:00 am to 7:00 pm Monday through Thursday and from 8:00 am to 2:00 pm on Friday. For more information or to schedule an appointment, please contact the Student Assistance Program at (909) 558-6050. The Student Assistance Program and Counseling Services office is located off campus at: Loma Linda Health Center, 11360 Mountain View Ave., Hartford Building, Suite A, Loma Linda, CA 92354

2. Other Covered Services and Expenses

The Plan also covers outpatient psychiatric treatment and marriage and family counseling, provided by physicians or licensed therapists in the community, including services provided by:

- clinical psychologists
- psychiatrists
- marriage and family therapists
- licensed clinical social workers

3. Partial Hospitalization

Partial hospital programs provided by a licensed acute care hospital for the treatment of mental illness or drug/alcohol rehabilitation may be covered on the same basis as inpatient psychiatric services if the services are authorized in advance by Risk Management.

4. Limitations:

- coverage for outpatient treatment is subject to a co-payment for each one-hour visit or fraction thereof
- professional services that are not provided by a preferred provider will be subject to 75% co-insurance (see section **XIV. Schedule of Benefits**)

5. Exclusions:

- biofeedback
- charges for missed or broken appointments
- court-mandated classes or programs
- hypnosis
- residential treatment programs for behavioral disorders or the treatment of drug or alcohol abuse
- services provided by unlicensed students, interns or counselors
- treatment for learning disabilities or developmental delay

J. Ambulance/Emergency Medical Evacuation

1. Covered Services and Expenses

Air or ground ambulance or medical evacuation service.

2. Limitations:

- all ambulance or medical evacuation services are only covered if required due to life-threatening Emergency Medical Conditions such as heart attack, bleeding, severe breathing difficulty, unconsciousness, and serious injury or illness (see section **XIII. Definitions)**

- air ambulance services are only covered for an Emergency Medical Condition if the patient cannot otherwise be transported by ground ambulance because of the severity of the patient's condition and if the air ambulance will result in a significantly faster transport to the nearest appropriate medical facility

- ambulance or medical evacuation coverage will only be provided for transport to the nearest medical facility capable of treating the Emergency Medical Condition

3. Exclusions:

- There is no coverage for the transportation expenses of anyone accompanying a patient during medical evacuation.

- There is no coverage or reimbursement for city or county fees charged for accessing 911 emergency services.

K. Vision Care

1. Covered Services and Expenses

Vision coverage includes:

- examination (subject to medical co-payment)

2. Exclusions:

- attachments to glasses or other devices used for magnification or visual correction

- contact lenses and fitting fees

- prescription or non-prescription glasses, sunglasses or frames

- prescription goggles for sports activities

- safety glasses

- vision therapy and orthoptics

L. Hearing Care

1. Covered Services and Expenses

Hearing coverage includes:

- examination (subject to medical co-payment)
- audiometricians (only by referral of medical doctor)
- hearing specialists

2. Exclusions:

- batteries for hearing aids
- hearing aids

M. Prescription Drugs

1. CVS Caremark Prescription Drug Benefit

The prescription drug benefit under the Plan is provided through CVS Caremark. Each student and spouse who enrolls in the Plan will receive a CVS Caremark/Health Plan Identification Card that can be used at any CVS Caremark participating pharmacy. The cost of the prescription is billed directly to the Plan after the student pays a co-payment. Drugs purchased directly from a pharmacy or hospital without the use of the CVS Caremark card (except for certain specialty drugs, as described below under "Exclusions") and drugs not covered by CVS Caremark will not be reimbursed under the Plan.

2. Retail Prescriptions

With the use of your CVS Caremark card, there is a flat co-payment amount (except for those drugs used for the treatment of sexual dysfunction). The standard 30-day co-payment amounts are $15.00 for generic drugs and $30.00 for brand name drugs that are dispensed by the CVS Caremark Mail Order Pharmacy, LLUMC Outpatient Pharmacy, the Faculty Pharmacy (located in the FMO building), the LLU Community Pharmacy (located in the Professional Plaza), the Meridian Pharmacy, the Highland Springs Pharmacy (located at Highland Springs Medical Plaza) and the LLUMC-Murrieta pharmacy.

For retail prescriptions filled at any other participating CVS Caremark pharmacy, there will normally be a $25.00 co-payment for generic products or a $40.00 co-payment for brand name drugs.

If a member voluntarily chooses to obtain a brand name drug when a generic equivalent drug is available, the student will be required to pay the difference in cost between the brand drug and the generic alternative in addition to the generic drug co-payment amount.

A 50% co-insurance requirement applies to any prescription for the treatment of sexual dysfunction. Prescription drugs used for the treatment of erectile dysfunction will only be covered if the person is a male over the age of 18 and there is a diagnosis of organic erectile dysfunction. Prescriptions for sexual dysfunction will be also limited to 6 doses per month.

3. Mail Order Prescriptions

Plan members also have the option of obtaining prescription drugs through the CVS Mail Order Pharmacy. This option allows members to save time and money with the convenience of mail delivery. After a one-time set up process, CVS will arrange for automatic prescription refills. Through this program, members may obtain a 30-day supply of drugs with a single co-payment and up to a 90-day supply of drugs with the payment of two (2) co-payments. This means that a student obtaining a 90-day supply of medication can save four co-payments per year by using the mail order option. This mail order option is only offered through the CVS Mail Order Pharmacy.

Note: The co-payment is waived, providing 100% coverage for a generic prescription filled through CVS

Mail when the medication is for the treatment of asthma, cholesterol, diabetes, heart failure or hypertension.

Additional prescription drug information and resources are also available at the CVS Caremark web site www.caremark.com and with the free CVS Caremark mobile app. These resources allow you to obtain refills on-line, scan your prescription bar code, set up mail order delivery, view your prescription history, track your prescription spend and check drug coverage and costs. To sign up for mail delivery service, go to caremark.com/mailservice . This site will allow you to register or sign-in to your account. Please have your health plan/prescription drug card available. Alternatively, you can call CVS Caremark Customer Care at 1-800-966-5772 to fill a prescription or obtain more information.

If you submit your prescription through the mail service, the prescription will be mailed directly to your home address and your co-payment will be billed to your credit card. CVS Caremark cannot accept cash or checks for co-payments.

4. Out-of-Pocket Maximum

Your out-of-pocket co-payments and co-insurance amounts for prescriptions covered under this Plan are limited to an annual aggregate maximum of $3,500 per individual and $7,000 per family.

5. Covered Items:

- prescription drugs that, under applicable state law, may only be dispensed by written prescription of a physician or dentist
- legend contraceptives, diaphragms, intrauterine devices (IUD's), Norplant and depo provera for birth control
- insulin, including syringes for insulin use

6. Limitations:

- drugs used for the treatment of sexual dysfunction will be subject to 50% co-insurance
- prescriptions for erectile dysfunction will be limited to covered males over the age of 18 with a diagnosis of organic erectile dysfunction
- prescriptions for erectile dysfunction will be limited to 6 doses per month
- drugs used for the treatment of migraine headaches and influenza will be subject to the recommended dosage limit for a 30 or 90-day supply based on the amount of each drug that is normally required for standard treatment

7. Exclusions

The following items are NOT reimbursable, even if prescribed by a physician:

- any drugs used for cosmetic purposes, including but not limited to Minoxidil (Rogaine) for baldness and Tretinoin (Retin-A) for wrinkles
- any drugs used for the treatment of a work-related illness or injury
- drugs prescribed for off label use that is not specifically approved by the U.S. Food and Drug Administration (FDA)
- drugs used for weight control

- experimental or investigational medical treatment or drugs
- first aid supplies
- non-prescription contraceptive foams, medications, materials or birth control devices
- non-prescription drugs other than insulin
- prescriptions not filled with your CVS Caremark prescription drug card**
- vitamins and nutritional supplements

***** If a specialty or "bio-tech" medication is not available under the CVS Caremark prescription drug benefit, you may be eligible for partial reimbursement under the Plan equal to 80% of the Allowable Charges if you obtain prior authorization from Risk Management. Any coverage is subject to the Plan limitations and exclusions. Contact Risk Management for prior authorization or additional coverage information.

N. Repatriation

1. Covered Services and Expenses

If a covered person dies while outside of the United States, the Plan will provide reimbursement of reasonable and necessary expenses required for the repatriation of the deceased's remains back to the U.S. as outlined in section **XIV. Schedule of Benefits**.

2. Limitations:

- coverage is only provided for expenses incurred to meet the minimum legal requirements for the preparation and transportation of the deceased's remains.

3. Exclusions:

- there is no coverage for the transportation expenses of anyone accompanying the body or funeral expenses

V. DENTAL COVERAGE

A. Dental Services

1. Covered Services and Expenses

The Plan provides limited coverage for dental services provided at the LLU School of Dentistry Clinic up to a $1,000 annual coverage limit. The Plan does not provide coverage for any services outside of the School of Dentistry. Coverage is provided for;

Preventive Services including:

- bi-annual routine exams, including four (4) bitewing and four (4) periapical x-rays per year
- full mouth x-rays and panorex limited to once every three years
- teeth cleaning (twice yearly)
- fluoride treatment (twice yearly for eligible dependents under 18 years old)

Basic Services including:

- clinic visit and exam
- necessary diagnostic x-rays and pathology
- restorations (fillings) - amalgam, silicate cement, plastic and composite restorations
- endodontics - root canals, pulp capping
- non-surgical tooth extractions

2. Limitations:

- bitewing and periapical x-rays are not covered during any year that the patient receives full mouth x-rays
- sealants will only be covered on un-restored bicuspids and first and second molars, every three years

3. Exclusions:

- dental crowns, cast restorations, inlays, onlays, implants, dentures or a fixed bridge
- diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues
- hospital costs and any additional fees charged by the dentist for hospital treatment (please note, however, that these may be included as medical benefits, see section **IV. Medical Coverage**)
- oral surgery including wisdom tooth removal
- orthodontia services
- periodontics and root planning

VI. PLAN EXCLUSIONS

Notwithstanding any provision herein to the contrary, and in addition to the other exclusions set forth in this Plan, including Sections IV and V above, the following are excluded from coverage under the Plan:

- acupuncture services
- adoption expenses
- any charges or expenses related to or resulting from surrogacy
- any city or county fees for accessing 911 emergency services
- any outpatient dental services provided outside of the LLU School of Dentistry
- any facility or supply charges from a birthing center or related to a home delivery
- any services, treatments or supplies which are not expressly specified as being covered under the Plan
- attachments to glasses or other devices used for magnification or visual correction

- batteries
- behavior modification services
- biofeedback
- care and/or treatment for hair loss, including hair transplants, toupees, wigs, or drugs used for hair growth
- charges for completion of insurance forms, adoption forms or other legal documents and duplication of x-rays or any records
- charges for missed or broken appointments
- chiropractic services
- contact lenses and fitting fees
- convalescent hospital care, nursing home care, residential care of any kind, respite care, adult day health care, homemaker services, special day care, continuing care retirement facilities and assisted living facilities
- cosmetic procedures, except for reconstruction necessary due to illness, injuries or congenital birth defects sustained while covered by the Plan
- court-mandated classes or programs
- custodial care
- dental crowns, cast restorations, inlays, onlays, implants, dentures or a fixed bridge
- diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues
- drugs prescribed for off label use that is not specifically approved by the United States Food and Drug Administration
- drugs used for cosmetic purposes
- drugs used for the treatment of infertility
- drugs used for weight control
- elective abortions
- exercise or fitness equipment
- expenses incurred outside of the U.S. (except for emergency medical services)
- expenses the covered person does not have a legal obligation to pay, or services provided to the covered person under a pre-paid medical or dental plan such as a Health Maintenance Organization (HMO)
- experimental or investigational medical procedures, treatment, drugs, services or supplies
- first aid supplies

- hearing aids
- hypnosis
- infertility treatment or diagnosis
- massage services, unless provided by a licensed therapist in conjunction with authorized physical or occupational therapy
- non-prescription contraceptive foams, medications, materials or birth control devices
- nonprescription drugs other than insulin
- obesity management, surgery and/or any related services or treatment, including complications from obesity services or treatment
- oral surgery including wisdom tooth removal
- orthodontia services
- periodontics and root planing
- personal convenience items (including clothing of any kind)
- physical examination or testing for the purpose of licensing, insurance, employment, immigration or other non-preventive purposes
- prenatal classes and parent training courses
- prescription or non-prescription glasses, goggles, sunglasses or frames
- prescriptions not filled with your CVS Caremark prescription drug card
- private duty nursing
- refractive eye surgery laser vision correction or any other medical treatment or procedures intended to improve the refraction character of the eye
- repair of any durable medical equipment
- replacement or duplication of any durable medical equipment that is still functional
- residential treatment programs
- reversals or revisions of any procedures which are intended to alter the refractive character of the eye and any related complications from these procedures
- reversal of voluntary or surgically induced infertility or the treatment of infertility following such a procedure
- sales tax or charges for shipping and handling
- services and facilities provided by or in a hospital owned or operated by a federal government or any

agency thereof for a disability related to military service

- services and supplies not certified as necessary by a licensed health care professional and/or physician
- services or expenses incurred prior to the date coverage is in force or after the date coverage terminates
- services or supplies provided more than twelve (12) months prior to the date the charges were submitted to the Plan for payment
- services provided by or ordered by the patient or a person who ordinarily resides in the home of a patient or an immediate family member
- services provided by unlicensed students, interns or therapists or counselors
- services that are not medically necessary for the diagnosis or treatment of an illness or injury (except for services provided in conjunction with a routine physical exam)
- social worker visitation or consultation
- special charges for services rendered after normal office hours or on weekends
- special shoes or other devices or appliances for the treatment of bunions, corns, calluses, toenails or similar conditions of the feet
- the removal of cosmetic breast implants or the treatment of any medical complications related to cosmetic breast implants
- transportation expenses (other than ambulance)
- treatment for learning disabilities or developmental delay
- treatment of calluses, corns or toenails by surgical incision, except for the removal of nail roots or the treatment of foot related vascular or metabolic disorders unless the patient's underlying medical condition requires such treatment
- treatment of a work-related illness or injury
- vision therapy and orthoptics
- vitamins and nutritional supplements

VII. COVERAGE AVAILABLE FROM OTHER SOURCES

Situations may arise in which your healthcare expenses may be the responsibility of someone other than this Plan. Here are descriptions of situations that may arise.

A. Third Party Liability

An individual covered by the Plan may have a legal right to recover Benefits or healthcare costs from another person, organization or entity, or an insurer as a result of an illness or injury for which Benefits or healthcare costs were paid by this Plan. For example, an individual who is injured may be able to recover the Benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, uninsured motorist coverage and under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers'

compensation insurer may be responsible for healthcare expenses connected with the illness or injury.

Definitions: For purposes of this Section relating to third party recoveries, the following definitions apply:

- **Covered Individual** means an individual covered by the Plan, including a spouse or dependent of a student. Covered Individual also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by the Plan, and includes any trust established for the purpose of receiving Recovery Funds and paying for the future income, care or medical expenses of such individual.
- **Benefits** means any amount paid by the Plan, or submitted to the Plan Administrator for payment to or on behalf of the covered individual. Bills, statements or invoices submitted by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of Benefits by the Covered Individual.
- **Third Party** means any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the covered individual. Third Party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage, auto medical payments coverage and workers' compensation insurance.
- **Third Party Claim** means any claim, settlement, award, lawsuit, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the covered individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of medical expenses from the Plan, may file a Third Party Claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, the Plan is still entitled to recover Benefits as described herein.)
- **Recovery Funds** means any amount recovered from a Third Party.

If a Covered Individual has a right to recover Benefits or healthcare costs from a Third Party, the Plan will pay the Covered Individuals' expenses subject to an automatic lien in the Plan's favor to the extent of Benefits paid, upon any compensation received from the Third Party, up to the sum of the amount paid by the Plan to perfect the lien and the amount paid by the Plan for the Benefits. The total lien amount will not exceed one-third of the money awarded to the Covered Individual under any final judgment, compromise, or settlement agreement if he or she retained an attorney, or one-half of the money awarded to the Covered Individual under any final judgment, compromise, or settlement agreement if he or she did not retained an attorney. If the Covered Individual is found by a judge, jury or arbitrator to be partially at fault then the lien shall be reduced by the same comparative fault percentage by which the Covered Individual's recovery was reduced. The lien amount is also subject to pro rata reduction, commensurate with the Covered Individual's reasonable attorney's fees and costs, in accordance with common fund doctrine. The above-described limitations on the total amount of the lien do not apply to liens made against workers' compensation claims, liens for Medi-Cal benefits, or liens for hospital services and hospital-affiliated health facility services.

If Benefits have been paid, or payment of Benefits is pending, the Plan is entitled to recover the amount paid or the amount pending payment from the proceeds of any recovery made by a Covered Individual against a Third Party. This Section applies to any Covered Individual for whom payment of benefits is made whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by the Plan.

Under this Section relating to Third Party recoveries, if the Plan has provided any Benefits, the Plan will be entitled to recover the amount paid from the proceeds of any recovery made by a Covered Individual against a Third Party. Upon claiming Benefits, or accepting payment of Benefits, or claiming or accepting the provision of Benefits from the Plan, the Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of reimbursement or subrogation as discussed in this Section. In connection with the Plan's rights to obtain reimbursement or exercise its rights as described below, the Covered Individual shall do one or more of the following things and agrees that the Plan Administrator may do one or more of the following things:

- If the Covered Individual seeks payment by the Plan of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify the Plan Administrator of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of Benefits is a bill or invoice submitted to the Plan Administrator by a provider to the Covered Individual.
- Upon request from the Plan Administrator, the Covered Individual shall provide all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify the Plan Administrator in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by the Plan from the Third Party.
- The Plan requires that any Covered Individual seeking payment of Benefits by the Plan, and if the Covered Individual is a minor or legally incapable of contracting, then the covered person's parent or guardian, must fill out, sign and return a Third Party Recovery Agreement that includes a questionnaire about the accident and the potential Third Party recovery. This Agreement will include provisions consistent with the provisions of this Section, including an agreement to repay the Plan for any Benefits paid relating to the injuries for which the Covered Individual is seeking recovery from a Third Party. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third Party Claim, then the attorney must sign the Third Party Recovery Agreement, acknowledging the obligations described in the Agreement.
- If the Covered Individual makes a demand upon a Third Party, enters into settlement negotiations or commences litigation, the Covered Individual must not prejudice, in any way, the Plan's recovery rights under this Section. If a suit is filed by the Covered Individual, the Covered Individual agrees that the Plan Administrator may cause to be recorded a notice of payment of Benefits, and such notice will constitute a lien on any judgment or settlement. The Plan Administrator may also provide notice to the Third Party or its insurer. In the event of settlement, the Covered Individual must obtain the Plan Administrator's consent prior to releasing any Third Party from liability for payment of any expenses covered, paid or pending for payment by the Plan. The Covered Individual will hold the rights of and to Recovery Funds in trust for the Plan, up to the amount of Benefits paid or which are pending payment at the time of resolution of the Third Party Claim.
- For any Benefits provided, pending payment, or paid by the Plan, the Covered Individual shall promptly reimburse the Plan from any Recovery Funds, the full value of any such Benefits.
- To secure the Plan's rights to reimbursement for any Benefits paid or provided, the Covered Individual, by claiming or accepting payment or the provision of Benefits by the Plan hereby grants to the Plan a first priority lien against the proceeds of any Third Party Claim and assigns the Plan any Benefits the Covered Individual may have under any insurance coverage's, such lien and assignment to apply only to the extent of Benefits paid, provided, or pending for payment. The Plan's recovery is subject to the total lien limitation in the second paragraph of section A. VII. above.
- The Covered Individual shall cooperate with the Plan Administrator to protect the Plan recovery rights under this Section, and in addition, but not by way of limitation, shall:
    1. Sign and deliver such documents as the Plan Administrator may reasonably require to protect the Plan's rights.
    2. Provide any information relevant to the application of the provisions of this Section, including medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.
    3. Take such actions as the Plan Administrator may reasonably request to assist in enforcing the Plan's rights to be reimbursed from Third Party recoveries.
- If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by the Plan, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

- By accepting the payment of Benefits by the Plan, the Covered Individual agrees that the Plan has the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party. If the Plan Administrator chooses to intervene in the Third Party Claim, the Plan shall not be liable for any attorney fees or costs incurred by the Covered Individual in connection with the Third Party Claim, and the Plan shall have no obligation to reimburse the Covered Individual for such attorney's fees or costs.

- The Covered Individual agrees that the Plan Administrator may notify any Third Party, or Third Party's representatives or insurers of our recovery rights set forth herein.

If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts as requested, the Plan Administrator has the right to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, the Plan Administrator may notify medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.

If the Covered Individual continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, the Plan will provide Benefits for the continuing treatment of that illness or injury pursuant to the terms of this Third Party Claims Section and only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing medical treatment have been exhausted for that purpose.

Coordination of benefits (where the Covered Individual has healthcare coverage under more than one plan or health insurance policy) is not considered a Third Party Claim.

Even without your written authorization, the Plan Administrator may release to, or obtain from, any other insurer, organization or person, any information needed to carry out reimbursement from Third Party recoveries and the provisions of this Section.

Benefits paid by the Plan, funds recovered by any Covered Individual and funds held in trust over which the Plan has an equitable lien exist separate from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

The Plan Administrator has the sole discretion to interpret and construe these reimbursement and subrogation provisions. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

B. Motor Vehicle Insurance

The Plan will not provide coverage for healthcare costs to the extent that a Covered Individual's (including a covered dependent's) expenses are covered by motor vehicle insurance, including medical payments insurance. The Plan will advance payment of benefits over the amount covered by the motor vehicle insurance, subject to the Third Party Liability Section above. If the Plan has paid Benefits first, the Plan is entitled to any reimbursement from the motor vehicle insurer, under the Third Party Liability Section above. You must give the Plan Administrator information about any medical insurance payments available to the Covered Individual or the Covered Individual's covered dependents.

C. Medicare

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon Benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. The Plan reserves the right to coordinate

Benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through the Centers for Medicare and Medicaid Services (CMS).

D. Coordination of Benefits (COB)

The Coordination of Benefits (COB) provision applies when you or your dependents have health care coverage under more than one Plan. Plan, for purposes of this COB section, is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. When this Plan is the Secondary plan it will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

1. Definitions

A Plan, for purposes of this COB section, is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

a. Plan includes self-funded employee health plans, group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans unless permitted by law.

Each arrangement for coverage under a. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Plan means, in a COB provision, the part of the arrangement providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the arrangement providing health care benefits is separate from this Plan. An arrangement may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

If you or your dependents have coverage under any other Plan, the Student Health Plan will provide coverage on an excess or secondary basis and will only provide coverage after the other Plan has processed the claim. If you or your dependents have no coverage under any other Plan or insurance policy and are not eligible for any other Third-Party recovery, this Plan will pay as a primary Plan. When this Plan is primary, it provides coverage as described in the Plan document. When there is any other applicable coverage available, this Plan will provide excess coverage, and provide payment after those of another Plan and will reduce coverage so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

- If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

- If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the payment arrangement yielding the lowest fees shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits.

- The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.

2. Effect on the Benefits of this Plan

As excess coverage, this Plan will reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, this Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the Primary plan. This Plan will then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

3. Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to determine benefits payable under this Plan and other Plans. The plan administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The plan administrator need not tell, or get the consent of any person to do this. Each person claiming benefits under this plan must give any facts it needs to determine benefits payable.

4. Facility of Payment

If expenses that should have been covered under this Plan are paid by any other group-health plan or insurer, this Plan reserves the right to pay Plan benefits to such health plan or insurer. These amounts will be deemed to be Plan Benefits and to the extent of such payments, this Plan will be fully discharged from liability.

5. Right of Recovery

If the amount of the payments made by this Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

VIII. CLAIMS

A. Types of Claims.

A "***Claim***" under the Plan is any (a) request for pre-authorization (*e.g.* a request related to the pre-admission review described in section **IV. (D)**, or (b) request for direct payment or reimbursement made after an expense has been incurred. Different types of Claims are treated differently under the Plan. Below is a list of the various types of Claims for pre-authorization or direct payment or reimbursement that may be made by or on behalf of a member. **THE DECISION OF WHETHER OR NOT TO SEEK MEDICAL TREATMENT IS ALWAYS A MEMBER'S DECISION AND NOT THE PLAN OR PLAN ADMINISTRATOR'S DECISION. DECISIONS MADE BY THE PLAN OR THE PLAN ADMINISTRATOR RELATE ONLY TO THE PAYMENT OR REIMBURSEMENT OF MEDICAL, DENTAL AND OPTICAL EXPENSES.**

The following are the various types of Claims that may be made:

Concurrent Care Decision. Any decision by the Plan – after previously approving direct payment or reimbursement for an ongoing course of treatment provided over a period of time or a specific number of treatments – whereby the Plan subsequently reduces or terminates payment or reimbursement for the treatments before the end of such period or number of treatments (other than by Plan amendment or termination).
Pre-Service Claim. Any Claim for pre-authorization or direct payment or reimbursement that must be approved in advance of receiving medical care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).

Urgent Care Claim. Any Claim that has to be decided more quickly because the normal timeframes for you to make your health care decisions could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, subject you to severe pain that can't be adequately managed without the care or treatment addressed in the Claim. Any claim that a physician with knowledge of your condition determines meets this definition shall be treated as an Urgent Care Claim under the Plan.

Post-Service Claim. Any other type of Claim, including a Claim for reimbursement.

As the Plan administrator, the LLUH Department of Risk Management (Risk Management) processes claims on behalf of the Plan. Often a service provider will initiate the Claims process on a member's behalf, such as when the service provider contacts Risk Management with regard to a Pre-Service Claim or when a preferred provider bills Risk Management directly for services that are covered by the Plan. In addition, you or your Authorized Representative may file any Claim. An "***Authorized Representative***" is an individual authorized to act on behalf of a member or beneficiary in pursuing a Claim or appeal in accordance with procedures established by the Plan. For Urgent Care Claims, a health care professional with knowledge of the claimant's medical condition may act as an Authorized Representative. (A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law.) For information about appointing an Authorized Representative, contact Risk Management.

B. Your Responsibilities with Respect to Claims

In addition to having rights under the Plan, you also have responsibilities with regard to the proper filing of Claims. The following sets forth guidelines that clarify your responsibilities:

- You are responsible for providing complete and accurate eligibility and Claims information. You should attempt to complete all forms and answer all questions to the best of your knowledge.

- You should submit requests for payment as soon as you receive invoices or receipts. This allows providers to be paid promptly and provides you with current documentation as evidence of payment. **THE DEADLINE FOR FILING A CLAIM UNDER THE PLAN IS ONE YEAR FOLLOWING THE**

DATE OF SERVICE. Any Claim submitted after this deadline will not be paid.

- You are responsible for filing accurate Claims. If someone else such as your Authorized Representative files Claims on your behalf, you should review the information before it is submitted. If a service provider initiates the Claims process, you are responsible for ensuring that the service provider provides accurate and complete information.

- You should review the Explanation of Benefits form when it is returned to you to make certain that benefits have been correctly paid based on your knowledge of the expenses incurred and the services rendered.

- You should immediately notify Risk Management if you believe that Claim payments have been inappropriately made or if you believe that any Plan benefits have been paid in error.

- You should never allow another person to seek medical treatment under your identity. If your Health Plan Identification Card is lost, report the loss to Risk Management.

When a service provider initiates the Claims process, Risk Management will typically rely upon the information provided by the service provider and will make most requests for additional information directly to the service provider. Nonetheless, you are responsible for ensuring that the service provider has all necessary information to make a proper Claim. After receiving a Claim from a service provider, Risk Management reserves the right to contact either you, your Authorized Representative or the service provider for additional information. Delays in responding to these requests may delay the processing of a Claim.

C. How to Make a Claim

As indicated above, service providers must contact Risk Management directly for Claims that relate to pre-authorization and preferred providers normally bill Risk Management directly for any medical services that are covered under the Plan. In such instances, you are not responsible for filing an initial Claim because the service provider, by contacting Risk Management, will initiate the Claims process and Risk Management will process the Claim. Nonetheless, you are responsible for ensuring that the service provider has accurate and complete information so that it may properly initiate a Claim on your behalf. Students may be required to sign an assignment of benefits form and will be required to pay any co-payments at the time services are rendered.

If a provider does not contact Risk Management directly, you or your Authorized Representative must follow the following procedure to file a Claim:

1. Obtain a Benefit Request form from Risk Management.

2. Complete the patient information portion of the Benefit Request form. It is important that you carefully follow the instructions included with the form. If needed information is omitted, authorization or reimbursement could be delayed.

    - the patient information section must be completed on each Benefit Request form

    - separate forms must be submitted for yourself and each covered dependent

    - any related hospital, laboratory, x-ray, or optical itemized bill may be attached to the Benefit Request form along with the attending doctor’s bill; however, if they are submitted separately, they must be submitted with a separate Benefit Request form

    - if you received pre-authorization, attach your authorization number or other relevant information relating to the pre-authorization

3. Provide proof of Claim. In order for your Claim to be complete, you must provide proof of payment and documentation of the services provided. A paid receipt or cancelled check is appropriate proof of payment.

Original bills of providers are acceptable documentation of services if they are on the letterhead of the provider or on a Benefit Request form and contain the following information:

Name of patient	Diagnosis with ICD 10 code
Name of student and member ID number	Itemized list of charges
Date of service, treatment, or purchase	Amount of charge
Type of treatment	Amount paid by subscriber
CPT or ADA code for services provided	Provider's Federal Tax Identification Number

Note: Non-itemized receipts or hand written receipts or billings are not acceptable and will not be considered for reimbursement.

4. Submit original bills and Claim forms to: Loma Linda University Health
Department of Risk Management
197 E. Caroline Street
San Bernardino, CA 92408

Medical and dental expense bills, paid receipts and cancelled checks that have been submitted to Risk Management will not be returned. If you cannot submit originals because you have already submitted them to another plan that is the primary plan (see section **VII. Coverage Available from Other Sources**), Risk Management will accept copies of these bills. Because of the large volume of Claims processed, it is not possible to provide members with additional copies of any Claim documentation for tax or other purposes.

5. Keep records of your Claims. If you want to maintain personal records, be certain to keep copies of each medical/dental bill and paid receipt or cancelled check you submit and each Explanation of Benefits form that Risk Management sends to you after processing a Claim.

When filing a Claim for benefits under the Plan, it is necessary that accurate and complete information be provided. If relevant information is misstated or not disclosed, the benefit payments will be recalculated based upon the correct information and you will be obligated to refund the Plan for any overpayments received. If you refuse to submit any documentation requested by Risk Management or otherwise fail to cooperate in the processing of your Claim, your Claim will be processed based on the information Risk Management has received and this may result in the denial of a Claim that would have been approved had Risk Management been provided with more complete information to assess the Claim.

Any student or member who willfully and knowingly engages in an activity intended to defraud the Plan, including submitting fraudulent health care Claims, will face disciplinary action that may include suspension from school and may result in criminal prosecution. Furthermore, any person who receives a payment or benefit from the Plan to which he or she is not entitled will be required to fully reimburse the Plan.

D. Notice of Benefit Determination

After a Claim is reviewed by the Plan, a notice of benefit determination will be provided under the circumstances described below. For Urgent Care and Pre-Service Claims, a notice of benefit determination will be provided whether or not the Plan makes an adverse decision on the Claim. For Post-Service Claims and Concurrent Care Decisions, a notice of benefit determination will be provided only if the Plan makes an adverse decision on the Claim.

The timeframes for providing notice of a benefit determination generally start when a written Claim for benefits is received by the Plan. Notice of a benefit determination may be provided in writing by in-hand, mail, or electronic delivery. However, for an adverse decision on an Urgent Care Claim, notice may first be provided orally, which will be followed by written or electronic notice within 3 days. Note, “days” means calendar (not business) days. The timeframes for providing a notice of benefit determination are as follows:

- ***Urgent Care Claims***. As soon as possible considering the medical urgency, no later than 72 hours after the Plan

receives a Claim.

- ***Pre-Service Claims***. Within a reasonable period of time appropriate to the medical circumstances, no later than 15 days after the Plan receives a Claim. This timeframe may be extended for up to 15 days for matters beyond the Plan's control.

- ***Post-Service Claims***. In the case of an adverse decision, within a reasonable period of time, no later than 30 days after the Plan receives a Claim. This timeframe may be extended for up to 15 days for matters beyond the Plan's control.

- ***Concurrent Care Decisions***. If a previously approved ongoing course of treatment will be reduced or terminated (other than by Plan amendment or termination), notice will be provided sufficiently in advance to provide an opportunity to appeal and obtain a decision on appeal before the benefit is reduced or terminated.

If a member requests an extension of ongoing treatment in an urgent circumstance, notice of the benefit determination, whether or not adverse, will be provided as soon as possible given the medical urgency, but no later than 24 hours after the Plan receives the Claim – provided the Claim is submitted to the Plan at least 24 hours before the expiration of the prescribed time period or number of treatments.

If an extension is requested of on-going treatment in a non-urgent circumstance, the request will be considered a new Claim and decided according to Post-Service or Pre-Service Claim timeframes, whichever applies.

For Pre-Service and Post-Service Claims, the Plan may extend the timeframe for a decision on a Claim in certain cases. If an extension is necessary due to reasons beyond the control of the Plan, the claimant will be notified before the end of the initial timeframe (15 days for Pre-Service Claims; 30 days for Post-Service Claims) of the reasons for the delay and when the Plan expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the Claim, the notice will describe the required information that's missing, and an additional period of at least 45 days will be provided after the claimant receives the notice to furnish the information. The Plan's extension period will begin when the claimant responds to the request for additional information. The Plan will then provide notice of the benefit determination within 15 days after the response is received.

The notice of the decision with respect to any benefit claim under this Plan shall be written in a manner calculated to be understood by the claimant and, if the claim is wholly or partially denied, shall set forth (1) the specific reasons for the denial, (2) references to the pertinent Plan provisions on which the decision was based, (3) a description of any additional material or information needed to support the claim and an explanation why such material or information is necessary, (4) a description of this Plan's claims review procedures and the time limits applicable to such procedures and (5) (A) the internal rule, guideline, protocol or similar criterion, if any, relied upon with respect to such benefit denial or a statement that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request, or (B) if the benefit denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the benefit denial which applies the terms of this Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

E. Improperly Filed or Incomplete Claims

If a Pre-Service Claim is not made in accordance with the Plan's Claims Procedures, notice will be provided as soon as possible, but no later than 5 days after the Claim is received by the Plan. If the Claim is an Urgent Care Claim, notice will be provided within 24 hours. Notice of an improperly filed Pre-Service or Urgent Care Claim may be provided orally – or in writing, if requested by the claimant or Authorized Representative. The notice will identify the proper procedures to be followed in filing the Claim.

In order to receive notice of an improperly made Pre-Service Claim, a claimant or an Authorized Representative must have provided a communication regarding the Claim to Risk Management. The communication must include:

- the identity of the claimant;
- a specific medical condition or symptom, and
- a request for approval for a specific treatment, service or product.

If an Urgent Care Claim is missing information needed for a coverage decision, notice will be provided by the Plan as soon as possible, but no later than 24 hours after the Claim has been received by the Plan. The notice will identify the specific information necessary to complete the Claim. A claimant will have a reasonable amount of time considering the circumstances (but not less than 48 hours) to provide the required information. The Plan will then provide notice of the Claim decision as soon as possible, but no later than 48 hours after the earlier of:

- the Plan's receipt of the specified information; or
- the end of the time period given for providing the information.

F. How to File an Appeal

This booklet is the Plan Document. Every effort has been made to explain simply and clearly all the major provisions of the Plan. However, situations may arise that require interpretation of the Plan language or determinations involving other issues that affect Plan coverage and may result in an adverse decision. If you disagree with an adverse decision, you have the right to file an appeal. For purposes of this section "***Adverse Decision"*** refers to a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including if based on: (i) a failure of an individual to enroll in the Plan in a timely manner or an individual's being ineligible to participate in the Plan; (ii) a service not being covered by the Plan; (iii) expenses exceeding a Plan limit; (iv) application of utilization review; (v) services being provided outside of the Plan preferred provider network; (vi) a member's failure to obtain a required authorization; (vii) a service being characterized as experimental or investigational or not medically necessary or appropriate; and (viii) a Concurrent Care Decision.

The following procedures have been adopted to ensure that your appeal will be handled promptly and in a fair, reasonable, and consistent manner. Remember, it is important for you to stay within the deadlines set forth below for the filing of appeals.

If a claimant disagrees with an adverse decision, a claimant (or the Authorized Representative) must file a written appeal with the Plan within 180 days after receipt of the notice of adverse decision. If a timely appeal is not made, a claimant will lose the right to any relief in court, as the internal administrative appeal rights will not have been exhausted (which is a requirement for receiving relief in court).

The appeal should include the reasons it is believed the adverse decision was improper, and all additional facts and documents considered relevant in support of the appeal. The decision on appeal will consider all comments, documents, records and other information submitted, even if they were not submitted or considered during the initial Claim decision.

A new decision-maker will review the appeal. The appeal will not be decided by individuals who denied the Claim or that person's subordinate. The new decision-maker will not give deference to the original decision on the Claim. That is, the reviewer will give the Claim a "fresh look," and make an independent decision about the Claim.

If the Claim was denied based on medical judgment, the reviewer will seek information from a health care professional who has appropriate training and experience in the field of medicine involved in the Claim, and who neither was consulted in connection with the initial Claim denial nor is a subordinate of such individual. (A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, cosmetic or not medically necessary or appropriate.) The Plan will also identify any medical or other experts whose advice was obtained in considering the original decision on the Claim, whether or not the Plan relied on their advice.

For appeals of adverse benefit decisions involving Urgent Care Claims, the Plan will accept either oral or written requests for an expedited appeal. All necessary information, including the appeal decision, may be transmitted between the Plan and the claimant, Authorized Representative or health care providers by telephone, fax, e-mail or other available expeditious methods.

1. **Level 1 Appeal**

If you think that an adverse decision was incorrect, you may have your Claim reconsidered by writing to the Level 1 Health Plan Committee and filing an appeal. The Level 1 Health Plan Committee's decision makers are individuals who did not decide the initial Claim and who are not subordinate to persons who approve or deny initial Claims. Appeals may be submitted by you or, if you choose, by your Authorized Representative. You may also submit appeals on behalf of your covered spouse or children. The mailing address for the Level 1 Health Plan Committee is:

Loma Linda University Health
Department of Risk Management
ATTN: Level 1 Health Plan Committee
197 E. Caroline Street
San Bernardino, CA 92408

Appeals may also be sent via e-mail to: RiskManagementHealthPlans@llu.edu
It is important to follow these steps to aid in the review of your appeal:

- State your desired outcome from the appeal. What are you requesting?
- If you are appealing a Claim denial, state the specific reason or reasons that you believe your Claim should have been approved
- Include any facts, documentation or other information, or issues you consider to be important in support of your appeal.

In preparing for the review, you may request to review or receive copies of, free of charge, any documents, records and other information relevant to the Claim.

If your appeal is denied in whole or in part, the written response will refer you to the Level 2 appeal procedure should you wish to appeal the decision further

2. **Level 2 Appeal**

Very often, questions concerning an adverse decision can be resolved to your satisfaction with a Level 1 appeal. If, after receiving a decision on your Level 1 appeal, you still believe that your Claim has not been handled properly or that there are some points that the Level 1 Health Plan Committee may have overlooked, you may appeal to the Student Health Plan Appeals Committee.

To appeal to the Student Health Plan Appeals Committee, write to the committee requesting a further review of your Claim. A Level 2 request should be directed to:

Student Health Plan Appeals Committee
Post Office Box 1770
Loma Linda, CA 92354

If you disagree with an adverse Level 1 Committee decision, you (or your Authorized Representative) must file a written appeal with the Plan within 90 days after receipt of the notice of adverse decision. If a timely appeal is not made, you will lose the right to any relief in court, as the internal administrative appeal rights will not have been exhausted (which is a requirement for receiving relief in court).

The Level 2 appeal is the final step of the review process. Please include all additional information that will be of assistance in the review of your appeal. The information listed under Level 1 should also be sent to the Student Health Plan Appeals Committee. In preparing your appeal, you may submit a request to review any pertinent documents.

Once the Student Health Plan Appeals Committee receives your request for review, it will then carefully review the facts and points you have raised about your Claim, as well as the documents provided by you and Risk Management. The Student Health Plan Appeals Committee may require that the patient be examined by a medical or dental consultant selected by the committee prior to making a decision.

The decision of the Student Health Plan Appeals Committee on your appeal shall be final and binding. Benefits will be paid under this Plan only if the Student Health Plan Appeals Committee, in its sole discretion, determines that you are eligible for such benefits.

3. <u>Notice of Benefit Determination on Appeal</u>

After an appeal is reviewed by the Plan, a notice of decision on appeal will be provided within the timeframes specified below. A notice of decision on appeal will be provided whether or not the Plan makes an adverse decision on the appeal. The timeframes for providing a notice of decision on appeal generally start when a written appeal is received by the Plan. Notice of decision on appeal may be provided in writing through in-hand, mail, or electronic delivery. Urgent Care Claim decisions may be delivered by telephone, facsimile, or other expeditious methods. Note, “days” means calendar (not business) days. The timeframes for providing a notice of decision on appeal are as follows:

- ***Urgent Care Claim Appeals***. Level 1 and Level 2 as soon as possible considering the medical urgency, no later than 72 hours after the Plan receives the appeal.

- ***Pre-Service Claim Appeals***. Level 1 and Level 2 within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after the Plan receives each request for appeal.

- ***Post-Service Claim Appeals***. Level 1 and Level 2 within a reasonable period of time, but no later than 30 days after the Plan receives each request for appeal.

The notice of the appeal decision, whether Level 1 or Level 2, shall be written in a manner calculated to be understood by the claimant and, if the claim is wholly or partially denied on appeal, shall include (1) the specific reasons for the denial, (2) references to the pertinent Plan provisions on which the denial was based, (3) (A) the internal rule, guideline, protocol or similar criterion, if any, relied upon with respect to such benefit denial or a statement that such a rule, guideline, protocol or similar criterion will be provided free of charge to the claimant upon request, or (B) if the benefit denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the benefit denial which applies the terms of this Plan to the claimant’s medical circumstances or a statement that such explanation will be provided free of charge upon request.

G. Disablement or Death

In case of disablement or death, covered benefits may be paid to next of kin, or heirs.

IX. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Upon receipt of an order purporting to be a Medical Child Support Order, the Employer will follow the procedures established for reviewing such orders and will determine whether or not the order is a Qualified Medical Child Support Order (a “QMCSO”), as defined in section 609(a)(2)(A) of ERISA. If the order is a QMCSO, then the Employer will follow the procedures established for implementing such orders with respect to coverage under the Plan.

Procedures for Processing a National Medical Support Notice: Upon receiving a properly completed National Medical Support Notice (Notice) issued by a state child support enforcement agency (Issuing Agency), the Notice shall be treated as a QMCSO. If the Employer cannot comply with the Notice for one of the permitted reasons, the Employer must complete the Employer Response form included in Part A of the Notice specifying the reason(s) that the Employer cannot comply with the Notice and advise the Issuing Agency.

If the Employer can comply with the Notice, then it must forward a copy of Part B of the Notice (Plan Administrator Response form) to the Plan Administrator within 20 business days of the date of the Notice. The Plan Administrator must complete the Plan Administrator Response form to inform the Employer and the Issuing Agency if the Notice is a QMCSO. If the Notice is determined not to be a QMCSO, then the Plan Administrator must specify the reasons and notify the Issuing Agency and the affected parties of that fact. If the Notice is determined to be a QMCSO, the Plan Administrator must provide the effective date of enrollment of the child in the Plan, whether any waiting periods apply and what student contribution is necessary for coverage. Copies of the completed Notice must be given to the Employer, Issuing Agency and all affected parties. The Employer must then withhold the student's contribution amount from the student's pay.

If there is more than one health plan option and the student is not enrolled in any plan, the Plan Administrator must respond by requesting the Issuing Agency to select the option in which to enroll the child. The Plan Administrator should provide the Issuing Agency with summary plan descriptions (SPDs) or similar documents describing the options. If the Issuing Agency does not respond to this request within 20 business days, the Plan Administrator must enroll the child in the Plan's default option, if any. If the Plan has no default option, the Plan Administrator shall contact the Issuing Agency to obtain its decision. The Plan Administrator Response form must be completed within 40 business days from the date of the Notice, or sooner, if reasonable.

X. PLAN AMENDMENT OR TERMINATION

The Plan Sponsor and the Plan Administrator reserves the right to amend any provision of the Plan or terminate the Plan at any time without prior notice to covered persons (except as such notice otherwise may be required by law) and without their approval. The right to amend includes, but is not limited to, the right to curtail or eliminate coverage for any persons, treatment, procedure, or service, irrespective of whether any covered student, prior student, dependent, retiree or other person is receiving such treatment for any injury, defect, illness, or disease contracted prior to the effective date of the amendment. The right to amend also includes, but is not limited to, the right to modify the applicable buy-in amounts at any time for any group of covered persons. Any amendment or termination of the Plan can apply to all or some of the persons then covered by the Plan, or eligible to be covered by the Plan, at that time or at any future date. Any such amendment or termination will be adopted by an authorized administrative committee, by the Plan Administrator, or by any other person properly authorized to take such action.

XI. MEDICAL RECORD INFORMATION PRIVACY AND SECURITY

1. **Definitions**

The following definitions shall apply to this section **XI**.

(a) "Electronic Protected Health Information" or (e-PHI) is Protected Health Information, defined in subsection (c) below which is transmitted by or maintained in electronic media.

(b) "Privacy and Security Rules" means the regulations at 45 C.F.R. Parts 160 and 164, including all amendments thereto, which are promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the privacy and security provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH) and which protect the privacy and security of certain health information and give individuals rights with respect to that information.

(c) "Health Information" means any information, including genetic information, whether oral or recorded in any form or medium, that:

i. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

ii. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

(d) "Individually Identifiable Information" means information that is a subset of Health Information, including demographic information collected from an individual, and;

i. is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

ii. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(e) "Plan" means the Loma Linda University Student Health Plan.

(f) "Plan Administrator" means the Loma Linda University Health, Department of Risk Management.

(g) "Plan Administration Functions" means administration functions performed by the Sponsoring Student of the Plan on behalf of the Plan and excludes functions performed by the Sponsoring Student in connection with any other benefit or benefit plan of the Sponsoring Student.

(h) "Protected Health Information" or "PHI" means Individually Identifiable Information which is transmitted by or maintained in electronic media or any other form, and generally includes Individually Identifiable Information held by or on behalf of the Plan. Protected Health Information excludes Individually Identifiable Information; (i) in education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) in records described at 20 U.S.C. 1232(a)(4)(B)(iv); (iii) in employment records held by a covered entity in its role as employer; and (iv) regarding a person who has been deceased for more than 50 years.

(i) "Plan Sponsor" means LLU.

(j) "Summary Health Information" means information that may be Individually Identifiable Information, and;

i. that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan; and

ii. from which the identifying information described at 45 C.F.R. § 164.515(b)(2)(i) (including the name of the individual and all dates directly related to the individual (such as birth date, admission date, discharge date, date of death), the individual's telephone number, fax number, electronic mail address, social security number, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers and serial numbers including license plate number, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol address numbers, biometric identifiers including finger and voice prints, full face photographic images and any comparable images, any other identifying number or characteristic or code, and all geographic subdivisions smaller than a State has been deleted, except, that the first three digits of a zip code may be used if the geographic unit formed by combining all zip codes within the same three digits contains more than 20,000 people and the initial three digits of a zip code for all such units containing 20,000 or fewer people is changed to 000, as described in 45 C.F.R. § 164.514(b)(2)(i)(B).

2. **Requests for Health Information by Plan Sponsor**

Permitted Uses and Disclosures. The Plan Sponsor may use and request PHI in accordance with the Privacy and Security Rules, as follows:

(a) Summary Health Information may be disclosed by the Plan to the Plan Sponsor (without a certificate described in Section 2(b) (Plan Sponsor Agreement to Restrictions and Certification), below, for the purposes of; (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan).

(b) The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

(c) Provided that the certification requirements in Section 2(b) (Plan Sponsor Agreement to Restrictions and Certification), below, have been met and the uses are consistent with the limited purposes provided for in such certification, the Plan may disclose PHI to the Plan Sponsor for purposes of Plan Administration Functions, and for the following uses permitted by the Privacy and Security Rules (in particular 45 C.F.R. Part 164, Subpart E (Privacy of Individually Identifiable Health Information):

i. Conducting quality assessment and improvement Information);

ii. Collection of individual premiums or contributions activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions;

iii. Reviewing health plan performance;

iv. Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;

v. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

vi. Business planning and development of the Plan, such as conducting cost-management and planning-related analyses, including formulary development and administration, development or improvement of methods of payment or coverage policies;

vii. Business management and general administrative activities of the Plan;

viii. Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

ix. Billing, claims management, collection activities, obtaining payment under a stop-loss contract, and related health care data processing;

x. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

xi. Utilization review activities;

xii. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; social security number; payment history; account number; name and address of the health care provider and/or health plan; and risk adjusting amounts due to enrollee health status and demographic

characteristics.

(d) *Plan Sponsor Agreement to Restrictions and Certification*. The Plan will not disclose PHI to the Plan Sponsor until it receives a certification by the Plan Sponsor that the Plan Sponsor agrees to:

i. Not use or further disclose the information other than as permitted or required by Plan documents or as required by law;

ii. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

iii. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or student benefit plan of the Plan Sponsor;

iv. Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the appropriate uses or disclosures of such information of which it becomes aware;

v. Make available Protected Health Information in accordance with the rules on individual access , pursuant to 45 C.F.R. § 164.524;

vi. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;

vii. Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

viii. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy and Security Rules.

ix. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

x. Ensure that the adequate separation required below in Section 2(c) is established

(e) Adequate Separation Between Plan and Plan Sponsor.

i. Only the following students of the Plan Sponsor shall have access to Protected Health Information; students who; perform Plan Administration Functions, perform human resource management functions, are members of the company benefit committee, work in the benefits department, or perform functions that support such students.

ii. Access to Protected Health Information shall be restricted to those individuals listed above in Section 2(c)(i) for the limited purposes of performing Plan Administration Functions.

iii. Any issues of non-compliance by persons listed above in Section 2(c)(i) shall be resolved by denying such person further access to PHI where appropriate and investigation by the Plan Administrator or the appropriate department of the Plan Sponsor. Any recourse for non-compliance shall be determined in accordance with the findings of the investigation and shall correlate to the severity of the non-compliance.

3. **Security Compliance of the Plan Sponsor**

As a condition for obtaining e-PHI from the Plan, it's Business Associates, Insurers, and HMOs, the Plan Sponsor shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation between the Plan and the Plan Sponsor as set forth in 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides e-PHI agrees to implement reasonable and appropriate security measures to protect such information;

(d) Report to the Plan any security incident of which it becomes aware. (for purposes of this Section, "security incident" shall mean the successful unauthorized access, use, disclosure, modification or destruction of e-PHI, or interference with system operations in an information system); and

(e) Upon request from the Plan, provide information to the Plan regarding any attempted but unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Plan Sponsor.

Notwithstanding the foregoing, the terms of this Section (Security Compliance of the Plan Sponsor) shall not apply to disclosures of; (i) Summary Health Information provided to the Plan Sponsor pursuant to 45 C.F.R. § 164.504(f)(l)(ii) or (iii); or (ii) e-PHI released pursuant to an authorization that complies with 45 C.F.R. § 164.508.

XII. PLAN INFORMATION

The official name of the Plan is the Loma Linda University Student Health Plan. The Plan is maintained to provide participating LLU Students and their eligible dependents with medical, surgical, hospital, optical, and limited dental care benefits. The Plan is self-funded and is not an insurance plan or health maintenance organization (HMO).

The Plan sponsor is:	Loma Linda University 11060 Anderson Street Linda, CA 92350
The Plan Administrator is:	Loma Linda University Health Department of Risk Management 197 E. Caroline Street San Bernardino, CA 92408 (909) 651-4010 or extension 14010
The agent for service of legal process is:	Loma Linda University Health Office of General Counsel 24890 Tulip Ave. Loma Linda, CA 92354

Legal process may also be served upon the Plan Administrator.

The Plan Year is: July 1 to June 30

XIII. DEFINITIONS

The following are definitions of some important terms used in this Plan document. Whenever used in this document, unless the context provides otherwise, whether italicized, highlighted, capitalized, or not, the terms have the meaning set forth in this section.

ADVERSE DECISION: a decision to deny, terminate, not provide or reduce benefits, including such a decision based on: (i) a failure of an individual to enroll in the Plan in a timely manner or an individual's being ineligible to participate in the Plan; (ii) a service not being covered by the Plan; (iii) expenses exceeding a Plan limit; (iv) application of utilization review; (v) services being provided outside of the Plan preferred provider network; (vi) a member's failure to obtain a required authorization; (vii) a service being characterized as experimental or investigational or not medically necessary or appropriate; and (viii) a concurrent care decision.

ALLOWABLE CHARGE: means the amount of an expense that qualifies for coverage under the Plan. In addition to other limitations and exclusions, allowable charges will be subject to a reasonable and customary limit representing the normal charge for the same service from other providers within the same geographic region. Reasonable and customary limitations will be established by the Department of Risk Management.

AUTHORIZED REPRESENTATIVE: means an individual specifically designated as the Plan member's representative in writing with notification sent to the Plan Administrator. See the Claims Procedures for more information.

BEHAVIOR MODIFICATION SERVICES: psychological enrichment or self-help programs for mentally healthy individuals including assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

CHILD or CHILDREN: any child who is under age 26 and:

- is a natural born or legally adopted child (including a child legally placed for adoption), or
- a stepchild (child of your spouse)
- an eligible foster child as defined in Code Section 152(f), or
- an individual for whom the student is required to provide coverage pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO") as defined in applicable federal law originally enacted as part of the Child Support and Incentives Act of 1998

CLAIM: any request for a Plan benefit or benefits made in accordance with the Claims Procedures. A communication regarding benefits that is not made in accordance with the procedures will not be treated as a claim.

CLAIMANT: an individual who has made a claim in accordance with the Claims Procedures.

CO-INSURANCE: the shared percentage cost of allowable charges to be paid by the enrollee.

CONDITION: a medical condition.

CO-PAYMENT: the fixed dollar amount of covered expenses to be paid by the enrollee.

COSMETIC PROCEDURE: any procedure performed for the improvement of a covered person's appearance, rather than for the improvement or restoration of bodily function.

COVERED DEPENDENT: an eligible dependent of a covered student of LLU who has been enrolled in the Plan.

COVERED STUDENT: an eligible student of LLU who is covered under this Plan following acceptance of the student's enrollment application and receipt of any required payment for coverage.

COVERED SERVICE: a service or supply that is specifically described as a benefit under this Plan.

CUSTODIAL CARE: care made up of services and supplies that:

- are furnished mainly to train or assist the individual family member in personal hygiene and other activities of daily living rather than to provide therapeutic treatment. Activities of daily living include such things as: bathing, feeding, dressing, walking, and taking oral medicines; or
- can safely and adequately be provided by persons without the technical skills of a licensed health care provider; or
- are primarily for the purpose of separating a patient from others, or for preventing a patient from harming himself or others.
- Such care is custodial regardless of:
  - who recommends, provides, or directs the care, or
  - where the care is provided, or
  - whether or not the individual family member can be or is being trained to care for himself or herself.

DAY: when used in the Claims Procedures, means a calendar day.

DEVELOPMENTAL DELAY: any significant lag in a child's physical, cognitive, behavioral, emotional, or social development, in comparison with norms.

DIVORCE OR DIVORCED: a judgment (i) of dissolution or annulment of a marriage or (ii) for legal separation of the spouses in a marriage as ordered by a court of competent jurisdiction. The effective date of a divorce/separation for purposes of the Plan is the earlier of the divorce or separation effective date set by the court in its divorce/separation order or the date on which the order is entered.

DOCTOR: a person who is properly trained and legally licensed to practice medicine and who is operating within the recognized scope of his or her practice, including a:

- physician licensed to practice medicine and/or surgery
- licensed osteopath
- certified or registered, licensed psychologist.

DURABLE MEDICAL EQUIPMENT: equipment that:

- can withstand repeated use, and
- is primarily and customarily used to serve a medical purpose, and
- is generally not useful to a person in the absence of an illness or injury, and
- is appropriate for use in the home.

ELECTIVE ABORTION: A voluntary interruption of pregnancy done at the request of the mother for reasons unrelated to concerns for maternal health or fetal disease.

ELIGIBLE DEPENDENT: your spouse and/or child who is eligible for coverage under this Plan. The eligibility provisions are set forth under section **II. Eligibility.**

EMERGENCY MEDICAL CONDITION: a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would (i) place the health of the individual (or, respect to a pregnant woman, her unborn child) in serious jeopardy, (ii) cause serious impairment to bodily functions, or (iii) cause serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES: the following services provided in connection with an Emergency Medical Condition: (i) a medical screening examination that is within the capacity of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under to stabilize the patient.

ENROLLEE or MEMBER: a covered student or covered dependent.

EXPERIMENTAL OR INVESTIGATIONAL: any procedure, treatment, drugs, services or supplies that are not considered to be standard treatment for the patient's diagnosis. Experimental or investigational includes but is not limited to those services considered experimental by governmental health care programs such as Medicare and MediCal and any treatment that requires Institutional Review Board (IRB) or FDA approval. The Plan Administrator shall have the sole discretionary authority to determine which procedures are experimental and excluded from coverage under the Plan.

HOSPICE: a program licensed and operated according to the law, which is approved by the attending physician to provide palliative, supportive and other related care to a covered person diagnosed as terminally ill.

HOSPITAL: an institution that fully meets every one of the following criterion:
- it is accredited by the Joint Commission on Accreditation of Health Care Organizations
- it is eligible to receive payments under Medicare
- it is accredited by the United States government or other authority accrediting hospitals in a foreign country
- it is primarily engaged in providing, for compensation and on an inpatient basis, facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians
- it continuously provides 24-hour registered nursing (R.N.) service
- it is not, other than incidentally, a place for rest for the aged, for drug addicts, for alcoholics, or a nursing home, or a facility providing custodial, education, or rehabilitative care.

ILLNESS: a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a covered person.

IMMEDIATE FAMILY: includes spouse, parent, brother, sister, child, step-child, grandchild, grandparent, mother-in-law, father-in-law, or either student’s or spouse's parents

INCURRED EXPENSES: those services and supplies rendered to a covered person. Such expenses shall be considered to have occurred at the time or date the service or supply was actually provided.

INJURY: physical injury or emotional harm or damage to a covered person caused by unexpected external means.

INPATIENT: the classification of a covered person when that person is admitted to a hospital or hospice facility for treatment, and charges are made for room and board to the covered person as a result of such treatment.

LEARNING DISABILITIES: conditions giving rise to difficulties in acquiring knowledge and skills to the level expected of those of the same age, especially when not associated with a physical handicap.

LEAVE OF ABSENCE: an approved personal leave processed in accordance with Loma Linda University policy.

MEDICALLY NECESSARY: health care services, supplies or treatment that are:
- recommended or approved by a Doctor or Dentist, and
- appropriate and consistent with the patient’s condition or diagnosis, and
- medically proven to be effective treatment of the condition, and
- not conducted for research purposes, and
- not performed mainly for the convenience of the patient or provider of medical and dental services, and
- in accordance with generally accepted medical or dental standards of good practice and could not be omitted without adversely affecting the patient's condition or the quality of the care rendered.

A service, supply or treatment will not be considered medically necessary merely because it is recommended or approved by a Doctor or Dentist. To be covered under the Plan, all the above criteria must be met. The Plan Administrator shall have the discretionary authority to determine which procedures are medically necessary.

MEDICARE: the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

MENTAL ILLNESS: any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services. The term also includes any other organic or inorganic condition, however caused, affecting the covered person's mental condition that is being treated by a psychiatrist, psychologist or other licensed mental health professional on an inpatient or outpatient basis. Mental illness includes such things as drug and alcohol abuse/dependency, schizophrenia and congenital encephalopathy.

ORTHOTIC APPLIANCE: an external device intended to correct any defect in form or function of the human body.

OUT-OF-NETWORK SERVICES: services that are obtained from any hospital, physician or other medical provider that is not listed as a contracted preferred provider under the Plan.

OUTPATIENT: the classification of a covered person when that covered person receives medical care, treatment, services, or supplies at a clinic, a physician's office, laboratory, radiology facility, outpatient surgery facility, or at a hospital, if not a registered bed-patient at that hospital.

OUTPATIENT SURGICAL FACILITY: a facility that meets *all* of the following requirements:

- is licensed as an outpatient surgery center
- is set up, equipped, and run to provide general surgery
- is directed by a staff of physicians, at least one of whom must be on the premises when surgery is performed and during the recovery period
- has at least one certified anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period
- extends surgical staff privileges to physicians who practice surgery and/or to dentists who perform oral surgery
- has at least two operating rooms and one recovery room
- provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery
- provides in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse
- is equipped and has trained staff to handle medical emergencies

PERSONAL CONVENIENCE ITEMS: personal comfort items, clothing or equipment, such as, but not limited to air conditioners, air-purification units, humidifiers, electric heating units, adjustable beds, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, slippers or special shoes, electric tooth brushes, non-prescription drugs and medicines and first aid supplies.

PLAN: Loma Linda University Student Health Plan

PLAN ADMINISTRATOR: The Plan is administered by the Loma Linda University Health, Department of Risk Management. The Plan Administrator exercises all discretionary authority and control over the Plan. The Plan Administrator shall have the discretionary authority to determine eligibility for benefits. As the Plan Administrator, Risk Management provides answers to your questions concerning the Plan, receives and processes all benefit claims, and makes payments and/or issues denials of payment based on Plan provisions. Please refer to section **III. B.** for Risk Management's address and phone number. Reference in this Plan to the Plan Administrator shall also include any person or entity to whom Risk Management has delegated any of its authority.

PLAN SPONSOR: Loma Linda University

PLAN YEAR: the Plan follows a calendar year from July 1 to June 30.

PREFERRED PROVIDER: means a hospital, physician or other health care professional who has entered into a contractual relationship to provide services at a discounted rate for Plan members. (A list of Preferred Providers is available from the Plan Administrator.)

PROSTHETICS: replacement of a missing part by an artificial substitute, such as an artificial extremity.

PSYCHIATRIC/COUNSELING SERVICES: the treatment or diagnostic services by a licensed physician, psychologist (Ph.D.), M.F.T., M.F.C.C. or L.C.S.W. and/or inpatient hospital services, in each case for mental illness.

REASONABLE AND CUSTOMARY: refers to the designation of a charge as being the usual charge made by a physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or expertise. The Plan Administrator shall have the discretionary authority to determine the reasonable and customary charges available for coverage under the Plan, and such determination shall be final and binding on all parties.

RISK MANAGEMENT OR DEPARTMENT OF RISK MANAGEMENT: the Plan Administrator assigned the responsibility for the administration of this Plan.

SPOUSE: a marriage partner or domestic partner recognized under the laws of the State of California. Some states allow common law marriage, which is a legally recognized marriage that lacks formal marriage proceedings: spouse does not include a spouse through common law marriage. Upon request, legal proof of marriage or domestic partnership must be submitted to the Plan Administrator.

TOTAL PERMANENT DISABILITY: in the case of a student, it is a permanent medical condition that prevents a student from performing any and every duty pertaining to an occupation or employment. In the case of a dependent, it is a permanent medical condition that results in the complete inability to perform the normal activities of a person of like age and sex in good health.

URGENT CARE: means the provision of immediate, short-term medical care for minor but urgent medical conditions that do not pose a significant threat to the life or health at the time services are rendered. To be considered urgent care services, care must be provided at a licensed urgent care facility.

WORK-RELATED ILLNESS OR INJURY: any illness or injury arising out of or in the course and scope of employment or self-employment for wages or profit so long as the covered person is not exempt from state and federal workers' compensation law. This includes all work-related illness or injury regardless of whether or not the associated treatment expenses are paid under a workers' compensation program.

XIV. LOMA LINDA UNIVERSITY
STUDENT HEALTH PLAN
SCHEDULE OF BENEFITS
7/1/2022

This schedule of benefits only provides a summary of the medical and dental coverage, limits, co-payments and co-insurance that apply to the Plan. For a complete description of the services covered under the Plan, as well as applicable benefit limitations, exclusions and conditions that apply to your coverage, please refer to the applicable section within this Plan document.

A. MEDICAL COVERAGE

Annual Out-of-Pocket Limits

Out-of-pocket co-payment and co-insurance maximum for medical services:
$3,500 per individual and $7,000 per family
Out-of-pocket co-payment and co-insurance maximum for prescription drugs:
$3,500 per individual and $7,000 per family

Co-insurance for out-of-network services and any co-payments or co-insurance for orthotics, prosthetics and any additional co-insurance for failure to obtain pre-admission authorization, charges above reasonable and customary limits or any other non-covered expenses will not apply toward the individual or family out-of-pocket maximum. In addition, these services are not subject to the maximum out-of-pocket limit.

Hospitalization and Surgery*	Annual Maximum Benefit	Coverage for Services At LLUH Facilities	Coverage at Other Hospitals
Medical, Surgical or Intensive Care Room and Board Expenses Miscellaneous Inpatient Expenses Surgery and Anesthesia Obstetrics (in-patient care) Inpatient Professional Fees		100%	25% of Allowable Charges
Skilled Nursing Facility			
Skilled Nursing Facility*	60 days	No PPO	100% of Allowable Charges

NOTE: FAILURE TO OBTAIN PRE-ADMISSION CERTIFICATION FOR NON-EMERGENCY HOSPITALIZATION OR SURGERY WILL RESULT IN A 50% REDUCTION IN BENEFITS.

Medical Outpatient Service	Annual Maximum Benefit	Coverage % for Preferred Providers	Out-of-Network Provider Coverage %
Preventive Care		100%	25% of Allowable Charges
Office Visits & Consultations		$40 co-pay/visit	25% of Allowable Charges
"E-visit" (a physician consultation via My Chart)		$10 co-pay	25% of Allowable Charges
CVS Minute Clinic Visit		$10 co-pay	
Laboratory and X-ray Services		100%	25% of Allowable Charges
Diagnostic Medical Services & Testing		100%	25% of Allowable Charges
Maternity Care (outpatient)		$400 co-pay/delivery	25% of Allowable Charges
Outpatient Surgery Charges*			
Facility Charges		100%	25% of Allowable Charges
Professional Fees		100%	25% of Allowable Charges
Home Care Services*	60 visits	100%	25% of Allowable Charges

	Maximum Benefit	Coverage % for Preferred Providers	Out-of-Network Provider Coverage %
Outpatient Psychiatric Care/Counseling			
Professional Counseling (including drug or alcohol treatment) A single visit is limited to one (1) hour of therapy		$10 co-pay/visit	25% of Allowable Charges
Electroconvulsive therapy (ECT)		$40 co-pay/treatment	25% of Allowable Charges
Outpatient Health Related Services			
Outpatient Medical Supplies*		80%	25% of Allowable Charges
Orthotics/Prosthetics*	$10,000	80%	25% of Allowable Charges
Physical/Occupational/Speech Therapy* One-year maximum, with required authorization		$40 Co-pay/visit	25% of Allowable Charges
Other Health-Related Professionals*		$40 Co-pay/visit	25% of Allowable Charges
Rental or purchase of authorized durable medical equipment*		80%	25% of Allowable Charges
Manual wheelchair*	$500	80%	25% of Allowable Charges
Electric wheelchair*	$2,500	80%	25% of Allowable Charges
Purchase of a Breast Pump	$500	No PPO	100% of Allowable Charges
Hospice Care*		100%	25% of Allowable Charges
Accident or Emergency Treatment			
Urgent Care Services		$40 Co-pay/visit	25% of Allowable Charges
Emergency Room Outpatient Visit		$200 Co-pay/visit	$200 Co-pay/visit

NOTE: Medical treatment is only covered as Emergency Services if the patient is being treated for an Emergency Medical Condition. If a patient is admitted to a hospital through the emergency department, or if the patient is held at the hospital in an "observation" status, the co-payment will normally be waived. If a patient seeks services at an out-of-network hospital emergency department for a condition that meets the Plan's definition of an Emergency Medical Condition, coverage shall apply in the same manner that coverage would have applied for services at a preferred provider. However, if a patient seeks services at an out-of-network hospital emergency department for a condition that does not meet the Plan definition of an Emergency Medical Condition, the out-of-network provider student co-insurance will apply.

	Maximum Benefit	Coverage % for Preferred Providers	Out-of-Network Provider Coverage %
Ambulance/Emergency Medical Evacuation			
Ambulance or Medical Evacuation (for life threatening conditions only)	$50,000	No PPO	$200 Co-payment/trip
Repatriation			
Repatriation Expenses	$25,000	No PPO	100% of Allowable Charges

	Annual Maximum Benefit	Coverage % for Preferred Providers	Out-of-Network Provider Coverage %
Vision Care			
Initial and Routine Examinations		No PPO	$40 co-pay/visit
Prescription Glasses & Contact Lenses		No Coverage	No Coverage
Hearing Care			
Audiometricians (by physician referral)		No PPO	$40 co-pay/visit
Hearing Specialists		$40 co-pay/visit	25% of Allowable Charges
Hearing Aids		No Coverage	No Coverage

Prescription Drugs

Mail Order Prescriptions – CVS Mail Order Pharmacy ONLY, (up to a 90-day supply)

$5 co-payment per generic prescription (two co-payments are required for more than a 31-day supply)

$30 co-payment per brand name prescription when no generic is alternative is available (two co-payments are required for more than a 31-day supply)

(50% coinsurance for erectile disfunction medications)

Prescriptions at a Retail Pharmacy (up to a 31-day supply)

LLUMC Pharmacy, Faculty Pharmacy, Meridian Pharmacy, LLU Community Pharmacy, Highland Springs Pharmacy and LLUMC-Murrieta Pharmacy:

$15 co-payment per generic prescription with use of CVS Caremark card

$30 co-payment per brand name prescription with use of CVS Caremark card (when no generic alternative is available)

All other CVS Caremark pharmacies:

$25 co-payment per generic prescription with use of CVS Caremark card

$40 co-payment per brand name prescription with use of CVS Caremark card (when no generic alternative is available)

If a member voluntarily chooses to obtain a brand name prescription when a generic prescription is available, the member will be required to pay the difference in cost between the brand name and the generic in addition to the generic drug co-payment (applicable to both retail and mail order prescriptions).

Impotency Drugs

Co-insurance equal to 50% of the Allowable Charges will apply to all prescriptions for drugs used to treat impotency.

Impotency drugs are only covered for male members over the age of 18 with a diagnosis of organic erectile dysfunction and are limited to 6 doses per month

Specialty drugs not available through CVS Caremark (Requires prior approval from Risk Management)		No PPO	80% of Allowable Charges

B. DENTAL COVERAGE

	Annual Maximum Benefit	% Coverage at the School of Dentistry	% Coverage for Other Dental Providers
Per Individual	up to $1,000/year		
Dental Care			
Preventive Services (routine exam & cleaning)		100%	No Coverage
Basic Services		80%	No Coverage
Major Services		No Coverage	No Coverage

*** Prior Authorization Required. Failure to obtain prior authorization will result in a 50% reduction in any benefits that require prior authorization.**

NO PPO -- There are no preferred providers for this service