# PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

**EBA&M**
**P.O. Box 5079**
**Westlake Village, CA 91359**

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Benefit Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Benefit Document of the Medical & Prescription Drug Benefits

**Plan Sponsor/Plan Administrator:** Garden Grove Unified School District

_____

Signed (authorized representative of Plan Sponsor) Date

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# GARDEN GROVE UNIFIED SCHOOL DISTRICT

## BENEFIT DOCUMENT

OF THE

## MEDICAL & PRESCRIPTION DRUG BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE
"GARDEN GROVE UNIFIED SCHOOL DISTRICT SELF-INSURED HEALTH PLAN"

RESTATED EFFECTIVE: JANUARY 1, 2017

*Contract Administrator:*

**EBA&M Corporation**
**P.O. Box 5079**
**Westlake Village, CA 91359**

**Phone: (800) 249-8440 / Fax: (714) 546-0141**

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# IMPORTANT INFORMATION

## WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

## THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

## THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

## GENETIC INFORMATION AND NON-DISCRIMINATION ACT

GINA (Genetic Information and Non-discrimination Act, effective 1-1-2010) prohibits group health plans from collecting genetic information and discriminating in enrollment and cost of coverage based on an individual's genetic information – which includes family medical information.

## DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

## PRE-TAX CONTRIBUTIONS

For members whose employee contributions for coverage are made on a pre-tax basis: The Internal Revenue Service (IRS) does not permit an Employee to make election changes or terminate participation outside of the Plan's Open Enrollment period unless he/she experiences an IRC "qualified change" or has a Special Enrollment Right as defined by the Health Insurance Portability and Accountability Act of 1996.

## MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

## CHILDRENS' HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Also, if an Employee's child(ren) become eligible for CHIP, Employee has the ability to drop the child(ren) from the group health coverage.

NOTES: CHIPRA allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

For more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

A "group health plan" does not include benefits provided under a health FSA or a high deductible health plan.

## KEEP THE PLAN INFORMED OF CHANGES

It is the responsibility of each Covered Person to assure that the Plan Administrator has current and accurate information regarding their eligibility, the eligibility of any qualified Dependents, and whether or not a Covered Person is enrolled in another health plan. Failure to notify the Plan Administrator in a timely manner can jeopardize eligibility for coverage and can even lead to termination of coverage and loss of eligibility for possible extended coverage (COBRA). See the Eligibility and Effective Dates, Termination of Coverage, Extension of Coverage Provisions and COBRA Continuation Coverage sections for more information.

To notify the Plan Administrator of changes, contact the Garden Grove Unified School District for the necessary form. Notifications must be made in writing and will require the Employee's name, the name(s) of any eligible Dependents affected by the change, a description of the change and the effective date of the change.

Some situations that would require notification to the Plan Administrator / Insurance Department include, but are not limited to:

Employee acquires a new Dependent – by marriage, birth, adoption, etc. **(must enroll within 31 days).**

Dependent no longer meets eligibility criteria – legal separation/divorce, Dependent child turns age 26, Dependent begins active military duty, etc. (**must notify within 60 days**).

Covered Person obtains coverage under another health plan (**must notify immediately**).

Contact the Plan Administrator / Insurance Department for more information

## COBRA NOTICE REQUIREMENTS

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee's or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-enrolled Employees. The procedures are also included herein and are located immediately following the **COBRA Continuation Coverage** section (see the **COBRA General Notice section**). Please review that section for additional details or contact the Plan Administrator for the most current notice procedures.

NOTE: It is important that the Plan Administrator be kept informed of the current addresses of all Covered Persons or beneficiaries who are or may become COBRA Qualified Beneficiaries.

# UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

## PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The name and phone number of the organization is shown on the Employee's coverage identification card.

**Compliance Procedures** - The procedures outlined below should be followed to avoid a possible penalty:

Inpatient Admission - Except as noted, at least (3) business days prior to any non-emergency Inpatient admission to a Covered Provider facility (Hospital, Skilled Nursing Facility, Inpatient mental health/ substance abuse facility, etc.), the Covered Person or someone acting on his behalf must contact the Utilization Management Organization (UMO) for authorization. For an emergency admission, the Utilization Management Organization should be contacted within 48 hours after admission, unless the Covered Person is incapacitated. "Incapacitated" means the physical or mental inability of the Covered Person to authorize his Hospital admission. If contact is not made prior to discharge, the admitting facility will have to file a "Retrospective Review" request with the Utilization Management Organization.

If, in the opinion of the patient's Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the UMO no later than the last authorized day.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery which does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.

Specified Outpatient Services & Supplies - Prior to receipt of the following services, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for authorization:

Home infusion (IV) therapy
Home health care
Potentially cosmetic/investigative services

Transplant Procedures - The Utilization Management Organization must be contacted for authorization prior to the performance of any transplant procedure.

## MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

## CASE MANAGEMENT SERVICES

The Utilization Management Organization provides case management for catastrophically ill or injured Covered Persons who require extensive medical services and who have exceptional or complex needs. Case managers are responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for Covered Persons who have been accepted into the case management program. To achieve this objective, the case management program works in collaboration with the Covered Person's team of health care professionals to provide feedback, support and assistance during the utilization and case management process.

Once a Covered Person is identified for potential case management, the Covered Person is contacted for program enrollment. The case manager will introduce and describe the program. The Covered Person can ask questions and agree or decline to participate. If the Covered Person declines to participate, a case manager may work with the health care treatment team to monitor progress through the healthcare continuum.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

**NOTE: Case Management is voluntary. There are no reductions of benefits or penalties if the patient chooses not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

# Anthem Contract Disclosure

**Out-of-Area Services**
Anthem Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the Anthem Blue Cross service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem Blue Cross and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Anthem Blue Cross service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. The payment practices in both instances are described below.

**BlueCard® Program**
Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem Blue Cross will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the Anthem Blue Cross service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Anthem Blue Cross

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem Blue Cross use[s] for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

**Negotiated (non-BlueCard Program) National Account Arrangements**
As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price made available to Anthem Blue Cross by the Host Blue.

**Non-Participating Healthcare Providers Outside Service Area**

Liability Calculation

When covered healthcare services are provided outside of the Anthem Blue Cross service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Anthem Blue Cross will make for the Plan/Fund as set forth in this paragraph.

Exceptions

In certain situations, Anthem Blue Cross may use other payment bases, such as billed covered charges, the payment Anthem Blue Cross would make if the healthcare services had been obtained within the Anthem Blue Cross service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Anthem Blue Cross will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Anthem Blue Cross will make for the covered services on behalf of the Plan/Fund as set forth in this paragraph.

# MEDICAL BENEFIT SUMMARY – EPO OPTION

This schedule applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the EPO Option. See "Choice of Coverage & Annual Election" in the **Eligibility and Effective Dates** section for more information.

## LIMITED CHOICE OF PROVIDERS

**WARNING: THIS OPTION PROVIDES COVERAGE ONLY WHEN NETWORK PROVIDERS ARE USED. PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.**

The Plan Sponsor has contracted with an organization or "Network" of California only health care providers. ALL HEALTH CARE must be provided by a California Physician in the Network. See "Emergency Care" (below) for the only exceptions to this requirement.

### ** IT IS THE RESPONSIBILITY OF EACH COVERED PERSON TO DETERMINE THE NETWORK STATUS OF THEIR MEDICAL PROVIDERS **

It is the responsibility of each Covered Person to determine the Network status of their medical providers in order to optimize the benefits they receive. While provider directories are helpful in this regard, it is not feasible for these to be 100% up-to-date at all times. Online directories are only updated periodically and providers can renew or revoke their Network contracts at any time**. IT IS BEST TO CONTACT PROVIDERS DIRECTLY, PRIOR TO AN APPOINTMENT, TO CONFIRM THEIR NETWORK STATUS**. It is also important to understand that each provider a Covered Person utilizes (Physician, lab, Surgical Center, etc.) is likely to be a stand-alone entity and may or may not be part of the Plan's Network. It should not be assumed that just because a particular Physician is a Network provider, that he/she will only make referrals to Network providers or facilities. Individuals should be especially cautious with regard to Surgical Centers as these can often be adjacent to or a part of a Physician's office, but they are typically a separate entity and may or may not be part of the Network.

**NOTE: No benefits are available for Non-Emergency treatment outside of California unless defined as the following**:

**Emergency Care -** In a Medical Emergency, a Covered Person should try to access a Network provider for treatment. However, if immediate treatment is required and this is not possible, the services of Non-Network providers will be covered until the patient's condition has stabilized to the extent that he/she can be safely transferred to Network provider care. At that point, if transfer does not take place, Non-Network benefit levels will apply.

For these purposes, an "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur:
  - There is inadequate time to effect safe transfer to another hospital prior to the delivery, or
  - A transfer poses a threat to the safety of the member or unborn child.

IMPORTANT: SOME HEALTH CARE SERVICES REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

## SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the summary reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been deducted. The percentages apply to "Allowable Amount" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Allowable Amount" in the **Definitions** section for more information.

A "Co-Pay" is an amount the Covered Person must pay and the balance of the Eligible Expenses will be paid by the Plan unless a lesser percentage (%) is shown. Co-Pays are usually paid to the provider at the time of service.

**This is a NON-GRANDFATHERED Plan under the Patient Protection and Affordable Care Act (PPACA).**

| **MAXIMUM LIFETIME BENEFIT** | Unlimited for Essential Health Benefits listed below: |
|---|---|
| There is no limit to the total benefits payable for Essential Health Benefits. "Essential Health Benefits" under this Plan include: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity & newborn care, (5) mental health & substance use disorder services, (6) prescription drugs, (7) rehabilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services including oral and vision care.<br>NOTE: As a Self-funded Plan, GGUSD is not required to offer coverage for all items considered "Essential Health Benefits". Therefore, the following "Essential Health Benefits" are NOT covered under this Plan: (1) behavioral health treatment and (2) habilitative services and devices. | |
| **CALENDAR YEAR DEDUCTIBLES** | |
| Individual Deductible<br>Family Maximum Deductible | $300<br>$900 |
| Individual Deductible - The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year.<br>Family Maximum Deductible - If $900 in eligible medical expenses is incurred cumulatively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents. | |
| **OUT-OF-POCKET MAXIMUMS** | |
| Individual Out-of-Pocket Maximum<br>Family Out-of-Pocket Maximum | $2,500<br>$7,500 |
| Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $2,500 in any Calendar Year toward his/her share of Eligible Expenses that are not paid by the Plan. Once he/she has paid his/her out-of-pocket maximum, his/her Eligible Expenses will be paid at 100% for the balance of the Calendar Year.<br>Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and his/her Dependents) will not be required to pay more than $7,500 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.<br>Co-Pays, including medical and prescription, Coinsurance, and Deductibles for Essential Health Benefits DO apply to the out-of-pocket maximums.<br>NOTE: The out-of-pocket maximums do not apply to or include:<br>~ non-essential health benefits (intraocular cataract lenses and wigs) | |

| **ELIGIBLE MEDICAL EXPENSES** | **Covered Person Pays** | **Plan Pays** |
|---|---|---|
| **Acupuncture / Acupressure**, per visit | $25 Co-Pay | Balance |
| Acupuncture / Acupressure, Chiropractic Care, and Physical Therapy limited to a combined 60 visits per Calendar Year. | | |
| **Ambulance** | -0- | 100% |
| **Cataract Surgery** | (benefits are based on types of services rendered) | |
| The Plan will provide up to $2,000 in benefits, per surgery, for purchase of an intraocular lens in order that the patient's vision can be corrected to avoid the need for additional corrective lenses (e.g., glasses). | | |

IMPORTANT: SOME HEALTH CARE SERVICES REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

| **ELIGIBLE MEDICAL EXPENSES** | **Covered Person Pays** | **Plan Pays** |
|---|---|---|
| **Chiropractic Care**, per visit | $25 Co-Pay | Balance |
| Chiropractic Care, Acupuncture / Acupressure and Physical Therapy limited to a combined 60 visits per Calendar Year. | | |
| **Emergency Room Services** | $100 Co-Pay | Balance |
| Notes: Emergency Room Services provided in a Non-Network facility for a Medical Emergency will be allowed as billed until stabilized then patient must be transferred to a Network facility.<br>The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room. | | |
| **Extended Care Facility** | -0- | 100% |
| Limited to 60 days per Calendar Year. | | |
| **Hospice Care**<br>Inpatient Care, per day<br>Outpatient Services | <br>-0-<br>-0- | <br>100%<br>100% |
| **Hospital Services**<br>Inpatient Care<br>Other Outpatient Surgeries | <br>-0-<br>-0- | <br>100%<br>100% |
| Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see **Definitions**) or the Allowable Amount charge for an Intensive Care Unit. | | |
| **Mental Health / Substance Use Disorder Care**<br><u>Hospital Care</u><br>Inpatient Care<br>Other Outpatient Services & Supplies, per day<br><br><u>Physician Care</u><br>Inpatient Visits<br>Office Visits, per visit<br>Other Services | <br><br>-0-<br>-0-<br><br><br>-0-<br>$25 Co-Pay<br>-0- | <br><br>100%<br>100%<br><br><br>100%<br>Balance<br>100% |
| Mental Health Care and Substance Use Disorder Care are covered same as Sickness. "Covered same as Sickness" means that the Plan's <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered mental health conditions or covered substance use disorders (see "Mental Health / Substance Use Disorder Care" in the **Eligible Medical Expenses** section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements). | | |
| **Physician Services**<br>Inpatient Visits<br>Office Visits, per visit<br>Other Services | <br>-0-<br>$25 Co-Pay<br>-0- | <br>100%<br>Balance<br>100% |
| NOTE: An "office visit" includes the charge for the visit as well as related X-rays, lab work, etc. which are performed during an office visit. Office visits for pre-and post-natal care require one Co-Pay per routine pregnancy. | | |
| **Prescription Drugs, Outpatient** | (see **Prescription Benefits Summary** section) | |
| **Preventive Care**<br>Federally-Required Preventive Care Services<br>Other Preventive Care Office Visits, per visit<br>Other Preventive Care Services | <br>-0-†<br>$25 Co-Pay<br>-0- | <br>100%†<br>Balance<br>100% |
| <u>Federally-Required Services</u>:<br>• evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force; | | |

| | | |
|---|---|---|
| • immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;<br>• for infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;<br>• for women, additional preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;<br>• for women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.<br><br>Other Preventive Care Services (to the extent they are not included in the Federally-Required Services):<br>• routine annual pap smear;<br>• routine annual mammogram;<br>• routine annual hearing screenings for persons up to age 22;<br>• routine periodic physical examinations, related X-rays and lab work and routine immunizations and injections;<br>• 1 baseline colonoscopy after age 50. | | |
| **Rehabilitation Therapy**, per visit<br>(Occupational, Physical & Speech therapies) | $25 Co-Pay | Balance |
| Physical Therapy, Acupuncture/Acupressure, and Chiropractic Care limited to a combined 60 visits per Calendar Year. | | |
| **Sterilization Procedures**<br>Vasectomy<br>Tubal Ligation | <br>$25 Co-Pay<br>-0- † | <br>Balance<br>100% |
| **Urgent Care Facility**, per visit | $25 Co-Pay | Balance |
| **Wigs** | -0- | 100% |
| Limited to one wig and to $900 while covered under the Plan. | | |
| **All Other Eligible Medical Expenses** | -0- | 100% |

† Calendar year deductible does not apply

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

# MEDICAL BENEFIT SUMMARY – PPO OPTION

This schedule applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the PPO OPTION. See "Choice of Coverage & Annual Election" in the **Eligibility and Effective Dates** section for more information.

## CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (Non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible - see the Schedule of Medical Benefits, below. **Non-Network provider charges will be calculated at the Plan's Allowable Amount.**

Although there may be circumstances when a Network provider cannot be used, Non-Network provider services will be covered at the Non-Network benefit levels.

In the following limited circumstances, charges of a non-Network provider will be paid at the PPO benefit levels:

**Emergency Care -** In a Medical Emergency, a Covered Person should try to access a Network provider for treatment. However, if immediate treatment is required and this is not possible, the services of Non-Network providers will be covered until the patient's condition has stabilized to the extent that he/she can be safely transferred to Network provider care. At that point, if transfer does not take place, Non-Network benefit levels will apply.

For these purposes, an "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur:
  - There is inadequate time to effect safe transfer to another hospital prior to the delivery, or
  - A transfer poses a threat to the safety of the member or unborn child.

NOTE: Non-emergency referrals to a Non-Network provider are covered as Non-Network services or supplies. **It is the responsibility of the patient** to assure services to be rendered are performed by Network Physicians and facilities in order to receive the Network level of benefits.

## SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the summary reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been deducted. The percentages apply to "Allowable Amount" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Allowable Amount" in the **Definitions** section for more information.

A "Co-Pay" is an amount the Covered Person must pay and the balance of the Eligible Expenses will be paid by the Plan unless a lesser percentage (%) is shown. Co-Pays are usually paid to the provider at the time of service.

**This is a NON-GRANDFATHERED Plan under the Patient Protection and Affordable Care Act (PPACA).**

IMPORTANT: SOME HEALTH CARE SERVICES REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

| **MAXIMUM LIFETIME BENEFIT** | Unlimited for Essential Health Benefits listed below: |
|---|---|

There is no limit to the total benefits payable for Essential Health Benefits. "Essential Health Benefits" under this Plan include: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity & newborn care, (5) mental health & substance use disorder services, (6) prescription drugs, (7) rehabilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services including oral and vision care.

NOTE: As a Self-funded Plan, GGUSD is not required to offer coverage for all items considered "Essential Health Benefits". Therefore, the following "Essential Health Benefits" are NOT covered under this Plan: (1) behavioral health treatment and (2) habilitative services and devices.

| **CALENDAR YEAR DEDUCTIBLES** | |
|---|---|
| Individual Deductible | $300 |
| Family Maximum Deductible | $900 |

Individual Deductible - The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year.

Family Maximum Deductible - If $900 in eligible medical expenses is incurred cumulatively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

| **OUT-OF-POCKET MAXIMUMS** | **Network** | **Non-Network** |
|---|---|---|
| Individual Out-of-Pocket Maximum | $2,500 | $3,500 |
| Family Out-of-Pocket Maximum | $7,500 | $12,700 |

**Individual Out-of-Pocket Maximum** - Except as noted, a Covered Person will not be required to pay more than $3,500 for Non-Network or $2,500 for Network services and supplies or any combination thereof in any Calendar Year toward his/her share of Eligible Expenses that are not paid by the Plan. Once he/she has paid his/her out-of-pocket maximum, his/her Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

**Family Out-of-Pocket Maximum** - Except as noted, a covered family will not be required to pay more than $12,700 for Non-Network or $7,500 for Network services and supplies or any combination thereof in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

Co-Pays, including prescription and medical, Coinsurance, and Deductibles for Essential Health Benefits DO apply to the out-of-pocket maximums.

NOTE: The out-of-pocket maximums do not apply to or include:

~ amounts in excess of usual and customary allowances;

~ non-essential health benefits (intraocular cataract lenses and wigs)

| **ELIGIBLE MEDICAL EXPENSES** | **Network (Covered Person Pays)** | **Non-Network (Covered Person Pays)** |
|---|---|---|
| **Accident-Related Expense**, up to $500 | 0%† | 0%† |

The $500 benefit for accident-related expenses is available only for services which are received within 90 days following the accident. Other expenses will be covered in the same manner as a Sickness and will be based on the types of expenses incurred.

Expenses eligible for this $500 benefit include:

Anesthesia (& admin.)
Blood
Braces, Crutches
Casts, Splints, Trusses, Surgical Dressings
Diagnostic Services
Durable Medical Equipment
Hospital Room and Board & Ancillary Services
Oxygen (& equipment)
Physical Therapy
Physician Services
Prosthetics

NOTE: Self-inflicted injuries will not qualify for this benefit.

| | | |
|---|---|---|
| **Acupuncture / Acupressure**, per visit | $25 Co-Pay, then 20% | $25 Co-Pay, then 30% |
| **Ambulance** (air or ground) | 20% | 20% |

IMPORTANT: SOME HEALTH CARE SERVICES REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

| **ELIGIBLE MEDICAL EXPENSES** | **Network (Covered Person Pays)** | **Non-Network (Covered Person Pays)** |
|---|---|---|
| **Ambulatory Surgical Center**, per use | 20% | 30% of $600 + amount over $600 |
| **Cataract Surgery** | (benefits are based on types of services rendered) | |
| The Plan will provide up to $2,000 in benefits, per surgery, for the purchase of an intraocular lens in order that the patient's vision can be corrected to avoid the need for additional corrective lenses (e.g., glasses). | | |
| **Chiropractic Care**, per visit | $25 Co-Pay, then 20% | $25 Co-Pay, then 30% |
| **Emergency Room Services** | | |
| For an medical emergency | $100 Co-Pay, then 20% of billed charge | $100 Co-Pay, then 20% of billed charge until stabilized then subject to UCR. |
| For a non-medical emergency | $100 Co-Pay, then 20% of billed charge | 30% of $600 + amount over $600, subject to UCR. |
| Notes: Emergency Room Services provided in a Network facility will be allowed as billed and processed according to appropriate benefit level above.<br>Emergency Room Services provided in a Non-Network facility for a Medical Emergency will be allowed as billed until stabilized then subject to UCR. Non-Medical Emergency Services provided in a Non-Network facility will be subject to UCR.<br>The Emergency Room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the Emergency Room. | | |
| **Extended Care Facility**, per day | 20% | 30% of $600 + amount over $600 |
| **Hospice Care** | | |
| Inpatient Care, per day | 20% | 30% of $600 + amount over $600 |
| Outpatient Services | 20% | 30% |
| **Hospital Services** | | |
| Inpatient Care, per day | 20% | 30% of $600 + amount over $600 |
| Other Outpatient Services & Supplies, per day | 20% | 30% of $600 + amount over $600 |
| Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see **Definitions**) or the Allowable Amount charge for an Intensive Care Unit. | | |
| **Mental Health / Substance Use Disorder Care** | | |
| Hospital Care | | |
| Inpatient Care, per day | 20% | 30% of $600 + amount over $600 |
| Other Outpatient Services & Supplies, per day | 20% | 30% of $600 + amount over $600 |
| Physician Care | | |
| Inpatient Visits | 20% | 30% |
| Office Visits, per visit | $25 Co-Pay, then 20% | $25 Co-Pay, then 30% |
| Other Services | 20% | 30% |
| Mental Health Care and Substance Use Disorder Care are covered same as Sickness. "Covered same as Sickness" means that the Plan's treatment limitations and financial requirements that apply to covered mental health conditions or covered substance use disorders (see "Mental Health / Substance Use Disorder Care" in the **Eligible Medical Expenses** section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements).<br>The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room | | |

IMPORTANT: SOME HEALTH CARE SERVICES REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

| **ELIGIBLE MEDICAL EXPENSES** | **Network (Covered Person Pays)** | **Non-Network (Covered Person Pays)** |
|---|---|---|
| **Physician Services** | | |
| Inpatient Visits | 20% | 30% |
| Office Visits, per visit | $25 Co-Pay, then 20% | $25 Co-Pay, then 30% |
| Other Services | 20% | 30% |
| NOTE: An "office visit" includes the charge for the visit as well as related X-rays, lab work, etc. which are performed during an office visit. | | |
| **Prescription Drugs, Outpatient** | (see **Prescription Benefit Summary** section) | |
| **Preventive Care** | | |
| Federally-Required Preventive Care Services | 100%† | $25 Co-Pay, then 30% |
| Other Preventive Care Services: | | |
| Office Visits, per visit | $25 Co-Pay, then 20% | $25 Co-Pay, then 30% |
| Other Services | 20% | 30% |
| Federally-Required Services:<br>• evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force;<br>• immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;<br>• for infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;<br>• for women, additional preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;<br>• for women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.<br>Other Preventive Care Services (to the extent they are not included in the Federally-Required Services):<br>• routine annual pap smear;<br>• routine annual mammogram;<br>• routine annual hearing screenings for persons up to age 22;<br>• routine periodic physical examinations, related X-rays and lab work and routine immunizations and injections;<br>• 1 baseline colonoscopy after age 50. | | |
| **Rehabilitation Therapy, Outpatient**, per visit | 20% | 30% |
| Rehabilitation Therapy includes occupational, physical & speech therapies. | | |
| **Wigs** | 20% | 20% |
| Limited to one wig and to $900 while covered under the Plan. | | |
| **All Other Eligible Medical Expenses** | 20% | 30% |

† Calendar year deductible does not apply

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

IMPORTANT: SOME HEALTH CARE SERVICES REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

# APPENDIX FOR FEDERALLY-REQUIRED PREVENTIVE CARE BENEFITS

When the following covered preventive care services are provided by a Network provider, a Covered Person will not have to a meet a deductible, pay a Co-Pay or pay a percentage share of the cost. See **IMPORTANT DETAILS** for coverage information when Non-Network providers are used.

Note: The following lists are subject to change periodically. Check the website references at the end of this section for the most up-to-date information.

**IMPORTANT DETAILS:**
Be aware that the plan is only required to provide these preventive services through a Network provider. The plan may allow a Covered Person to receive these services from a Non-Network provider, but the Covered Person may have to pay all or part of the cost. (See the **Medical Benefit Summary** for additional information.)

A doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that the plan can require the Covered Person to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if the doctor bills the claimant for the preventive service separately from the office visit.

A Covered Person should ask his health care provider to help him understand which covered preventive services are right for him – based on his age, gender and health status.

This exhibit outlines recommendations from the US Preventive Services Task Force which are relevant to the Preventive Care requirements under the Affordable Care Act (ACA).

| **COVERED PREVENTIVE SERVICES FOR ADULTS** (AGE 18 & OLDER) | | | |
|---|---|---|---|
| **Abdominal Aortic Aneurysm** | One-time screening for abdominal aortic aneurysm by ultrasound in men ages 65 to 75 years who have ever smoked | | |
| **Alcohol Misuse** | Screening and brief behavioral counseling interventions to reduce alcohol misuse for those persons engaged in risky or hazardous drinking | | |
| **Aspirin** | Recommended use for men ages 45 to 79 and women ages 55 to 79 for the prevention of heart disease | | |
| **Blood Pressure** | Screening for all adults | | |
| **Cholesterol** | Screening for men age 35 and older and women age 45 and older for lipid disorders; Screening for men age 20-35 and women age 20-45 if at increased risk for heart disease | | |
| **Colorectal Cancer** | Screening for adults age 50 to 75 | | |
| **Depression** | Screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up | | |
| **Diabetes (Type 2)** | Screening for adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg | | |
| **Diet** | Counseling for adults at higher risk for high cholesterol or heart disease | | |
| **Falls Prevention: Exercise / PT** | Exercise or physical therapy to prevent falls in community-dwelling adults age 65 and older who are at increased risk for falls | | |
| **Falls Prevention: Vitamin D** | Supplementation to prevent falls in community-dwelling adults age 65 and older who are at increased risk for falls. | | |
| **Hepatitis B Screening** | For adults at higher risk | | |
| **Hepatitis C Screening** | Screening for all adults at higher risk; one -time screening to adults born between 1945 and 1965 | | |
| **HIV** | Screening for all adults to age 65 or any adult at higher risk | | |
| **Immunizations & Vaccines** Doses, recommended ages and recommended populations vary | Hepatitis A<br>Hepatitis B<br>Herpes Zoster<br>Human Papillomavirus<br>Influenza | Measles<br>Mumps<br>Meningococcal<br>Pneumococcal<br>Tetanus | Diphtheria<br>Pertussis<br>Varicella<br>Rubella |

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

| | |
|---|---|
| **Lung Cancer Screening** | Annual screening for ages 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit within the last 15 years |
| **Obesity** | Screening and counseling for all adults |
| **Sexually-Transmitted Infection (STI)** | Prevention counseling for adults at higher risk |
| **Syphilis** | Screening for all adults at higher risk |
| **Tobacco Use** | Screening for tobacco use; and, for those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:<br>• Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and<br>• All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. |
| **ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN**<br>(AGE 18 & OLDER) | |
| **BRCA Risk Assessment and Genetic Counseling/Testing** | Screening for women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. |
| **Breast Cancer Mammography** | Standard 2D screenings every 1 to 2 years for women age 40 and older |
| **Breast Cancer Chemoprevention** | Counseling for women at higher risk |
| **Breast-Feeding** | Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women |
| **Cervical Cancer** | Screening for women age 21 to 65 with Pap Smear every 3 years or, for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of Pap Smear and human papillomavirus (HPV) testing every 5 years. |
| **Chlamydia Infection** | Screening for women age 24 and younger and other women at higher risk |
| **Contraception** | Food and drug administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs for all women of all ages with reproductive capacity. |
| **Domestic and Interpersonal Violence** | Screening and counseling for all women |
| **Folic Acid** | Supplements for women who may become pregnant |
| **Gonorrhea** | Screening for all women at higher risk |
| **Human Immune-Deficiency Virus** | Annual Screening and Counseling |
| **Human Papillomavirus / DNA Testing** | Screening beginning at 30 years of age, occurring no more frequently than every 3 years |
| **Sexually Transmitted Infections** | Annual counseling on sexually transmitted infections for all sexually active women |
| **Osteoporosis** | Screening for women age 65 and older; Screening for women younger than age 65 whose fracture risk is equal to or greater than that of a 65 year old white woman who has no additional risk factors. |

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

| | |
|---|---|
| **Well-woman visits** | An annual adult well-woman visit to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care |
| **PREVENTIVE SERVICES FOR COVERED PREGNANCIES** | |
| **Anemia** | Screening on a routine basis for pregnant women |
| **Bacteriuria** | Urinary tract or other infection screening for pregnant women at 12 to 16 weeks' gestation or the first prenatal visit, if later. |
| **Breastfeeding** | Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and cost for renting breastfeeding equipment. In conjunction with each birth. |
| **Gestational Diabetes** | Screening for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk of developing gestational diabetes |
| **Hepatitis B** | Screening for pregnant women at their first prenatal visit |
| **Human Immunodeficiency Virus (HIV)** | Screening and counseling for sexually active women |
| **Human Papillomavirus (HPV) DNA Test** | High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older |
| **Rh Incompatibility** | Screening for all pregnant women and follow-up testing for women at higher risk |
| **Tobacco Use** | Screening and interventions for all women, and expanded counseling for pregnant tobacco users |
| **Sexually Transmitted Infections (STI)** | Annual counseling on sexually transmitted infections for all sexually active women |
| **Syphilis** | Screening for all pregnant women or other women at increased risk |
| **COVERED PREVENTIVE SERVICES FOR CHILDREN** (BIRTH TO AGE 18) | |
| **Alcohol & Drug Use Assessment** | Adolescents |
| **Autism Screening** | 18 and 24 months |
| **Behavioral Assessments** | All children throughout development |
| **Blood Pressure** | Screening for children |
| **Cervical Dysplasia Screening** | Sexually active females |
| **Congenital Hypothyroidism Screening** | All newborns |
| **Dental Caries Prevention** | Application of fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption |
| **Depression** | Screening for adolescents (ages 12-18) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up |
| **Developmental Screening** | Children under age 3 and surveillance throughout childhood |
| **Dyslipidemia Screening** | Children at higher risk of lipid disorders |
| **Fluoride Supplements** | Starting at age 6 months and up to age 5 years for children whose water supply is fluoride deficient |
| **Gonorrhea Preventive Eye Medication** | All newborns |
| **Hearing Screening** | All newborns |
| **Height, Weight & Body Mass Index** | All children throughout development |

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

| | |
|---|---|
| **Hematocrit or Hemoglobin Screening** | All children |
| **Hemoglobinopathies/Sickle Cell Screening** | All newborns |
| **HIV Screening** | Adolescents age 15 to 18 or any adolescent at higher risk |
| **Immunizations & Vaccines** | Diphtheria<br>Tetanus<br>Pertussis<br>Haemophilus Influenza (Type b)<br>Hepatitis A<br>Hepatitis B<br>Human Papillomavirus<br>Inactivated Poliovirus<br>Influenza<br>Measles<br>Mumps<br>Rubella<br>Meningococcal<br>Pneumococcal<br>Rotavirus<br>Varicella |
| **Iron Supplements** | Children ages 6 to 12 months at risk for anemia |
| **Lead Screening** | Children at risk of exposure |
| **Medical History** | All children throughout development |
| **Obesity Screening & Counseling** | All children throughout development ages 6 years and older |
| **Oral Health Risk Assessment** | Young children |
| **Phenylketonuria (PKU) Genetic Screening** | All newborns |
| **Sexually Transmitted Infection (STI) Prevention Counseling and Screening** | Annual counseling on sexually transmitted infections for all sexually active adolescents |
| **Tobacco Use** | Education and counseling to prevent inhalation of tobacco use in school-aged children and adolescents. |
| **Tuberculin Testing** | Children at higher risk of tuberculosis |
| **Vision Screening** | All children at least once between the ages of 3 and 5 years |

**WEBSITE REFERENCES:**
**- Overview: https://www.healthcare.gov/preventive-care-benefits**
**- Regulation: http://www.uspreventiveservicestaskforce.org**

# ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (application of Deductible requirements and benefit sharing percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Allowable Amounts for the items listed below and that are incurred by a Covered Person - subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

NOTES: The Plan reserves the right to modify Eligible Expenses in accordance with recommendations of the Utilization Review Organization to assure that a Covered Person receives quality health care in the most cost-effective settings.

Certain services or supplies listed below may not be available through the Network.

**Acupuncture / Acupressure** - Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

**Alcoholism** - see "Mental Health / Substance Use Disorder Care"

**Allergy Testing & Treatment** - Individualized testing and treatment for allergies which do not exceed the guidelines recognized by the medical profession as appropriate treatment.

**Ambulance** - Licensed ground or air ambulance transportation to the nearest Hospital or Extended Care Facility where care and treatment of the illness or injury can be given. Covered services include:

base charge and mileage;

non-reusable supplies;

monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance services. Appropriately licensed persons must render such services.

**Ambulatory Surgical Center** - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

**Anesthesia** - Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

**Birthing Center** - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

**Blood** - Blood and blood plasma (if not replaced by or for the patient). Also, the Plan will cover charges related to processing and storage of autogenous blood (a Covered Person's own blood) prior to a scheduled surgical procedure, whether or not such blood is subsequently required by the Covered Person.

**Breast Cancer Susceptibility Gene (BRCA)** – Genetic counseling and BRCA testing, if appropriate for a woman as determined by her Health Care Provider under the following guidelines of the United States Preventive Services Task Force (USPSTF):

USPSTF recommends with a “B” rating that women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.

Please refer to the Appendix for Federally-Required Preventive Care Benefits.

**Cataract Surgery** - Placement of an intraocular lens in order that the patient’s vision can be corrected to avoid the need for additional corrective lenses (e.g., glasses).

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

**Chemical Dependency** - see "Mental Health / Substance Use Disorder Care"

**Chemotherapy** - The use of chemical agents in the treatment or control of disease. When administered on an Outpatient basis, treatment is subject to review by the Utilization Review Organization (see **Utilization Management Program**).

**Chiropractic Care** - Modalities (hot, cold therapy, etc.), manipulation and adjunctive therapy by a Covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

**Circumcision** - A newborn circumcision procedure.

**Clinical Trials -** Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in Approved Clinical Trials which are conducted in relation to the treatment of cancer or other life-threatening disease.

"Approved Clinical Trial" means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the FDA (if such application is required);

"Qualified Individual" means an individual who is eligible to participate in an Approved Clinical Trial and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

"Routine Patient Costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

**Contraceptives** – see the **Prescription Benefit Summary**.

**Dental Injury** - Services of a Physician (MD) or Dentist (DDS) treating an Accidental Injury to natural teeth. Services must be received during the six (6) months following the date of injury.

NOTE: Damage to natural teeth due to chewing or biting is not considered an Accidental Injury.

**Diabetic Supplies** - see the **Prescription Benefit Summary.**

**Diagnostic Lab & X-ray** - Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

**Dialysis Equipment & Supplies** - Dialysis supplies and rental or purchase of dialysis equipment.

**Durable Medical Equipment** - Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for temporary (generally for a period not to exceed six (6) months) therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes such items as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home. Eligible Expense will also include the purchase of a cardiac pacemaker.

NOTES: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.
Expenses for repair of durable medical equipment will be covered after one (1) year of use.

**Emergency Room Services -** Services required for a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in permanent physical impairment or loss of life.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

**Extended Care Facility** - Charges for necessary services and supplies made by an Extended Care Facility but only when confinement:

is preceded by confinement of at least three (3) days in a Hospital;

is for the same condition causing the preceding confinement;

commences within fourteen (14) days of discharge from such prior confinement;

is one during which the attending Physician continues treatment and certifies that twenty-four (24) hour nursing care is essential and that continuation of such confinement is necessary for treatment of the Sickness or Accidental Injury.

**Fertility Testing & Treatment** - Diagnostic testing for infertility and corrective surgical procedures.

NOTE: Testing and treatment coverage does not include any type of artificial impregnation procedure, ultrasounds, progesterone or other medications to increase or enhance the possibility of impregnation.

**Home Health Care** - Charges made by a Home Health Care Agency for the following services and supplies furnished to a Covered Person in accordance with a home health care plan. Home health care must commence within fourteen (14) days following termination of a Hospital confinement as a resident Inpatient, must be for the same or related condition for which the patient was hospitalized and must be in lieu of continued hospitalization. Eligible services include:

part-time or intermittent nursing care by a registered nurse (RN) or by a licensed practical nurse (LPN) if the services of a registered nurse are not available;

part-time or intermittent home health aide services which consist primarily of caring for the patient;

physical therapy, occupational therapy, and speech therapy;

medical supplies, drugs and medicines prescribed by a physician and laboratory services provided by or on behalf of a Hospital but only to the extent that such charges would have been covered under this Plan if the patient had remained in the Hospital.

NOTE: Covered home health care expenses will not include services of any social worker, transportation services, or any other services not specifically included as an Eligible Expense.

**Hospice Care** - Hospice care of a Covered Person with a terminal prognosis (life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice charges for:

Inpatient Hospice facility services and supplies;

Outpatient services (i.e., services provided in the patient's home) including, but not limited to: (1) nursing care by a registered nurse, a licensed practical nurse, a vocational nurse or a public health nurse who is under the direct supervision of a registered nurse, (2) physical therapy and speech therapy when rendered by licensed therapists, (3) medical supplies, including drugs and biologicals and the use of medical appliances, (4) Physician services, and (5) services, supplies and treatments deemed Medically Necessary and ordered by a Physician.

**Hospital Services** - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

**Medical Supplies, Disposable** – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

**Medicines** - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. See the **Prescription Benefit Summary** section for pharmacy drugs.

**Mental Health / Substance Use Disorder Care** - Services and supplies for the treatment of covered mental health conditions and covered substance use disorders. Treatment of covered mental health conditions and covered substance use disorders may be provided through Inpatient or Outpatient services, emergency care and prescription drugs.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

Except as expressly excluded in the **Medical Limitations and Exclusions** section, a "mental health condition" or "substance use disorder" will include those conditions listed in the International Classification of Diseases Manual in the section on mental disorders, including drug or alcohol intoxication or dependence. These disorders may be of physical or functional etiology. Many of these disorders are often referred to as "nervous and mental" or "psychiatric" conditions or problems.

**Midwife** - Services of a registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

**Newborn Care** - Routine Hospital nursery services provided during the birth confinement to a covered well newborn child, subject to the minimum requirements of the Newborns' and Mothers' Health Protection Act (i.e., up to 48 hours following normal delivery or 96 hours following cesarean section delivery). See "Pregnancy Care" for coverage information when the newborn is not a Covered Person under the Plan.

Eligible Medical Expenses, as listed herein, that are provided to a covered newborn child who requires treatment for a Sickness or Accidental Injury.

**Nursing Services - Private Duty** - Services of a registered nurse (RN) for private duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

**Nutritional Counseling** - Nutritional counseling when provided in connection with a diagnosis of diabetes, high cholesterol, or hyperlipidemia, limited to four (4) visits.

**Orthotics** - Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and custom made.

NOTE: Foot orthotics are not covered.

**Oxygen** - see "Durable Medical Equipment"

**Physician Services** - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

**Pregnancy Care** - Pregnancy-related expenses of a covered Employee or covered Dependent spouse. Eligible Pregnancy-related expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

pre-natal visits and routine pre-natal and post-partum care;

expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;

genetic testing or amniocentesis when performed on a Covered Person over the age of 35 or when deemed Medically Necessary by a Physician;

newborn Hospital services provided during the mother's confinement for delivery, limited to the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, (3) expenses of a surrogate mother who is not a Covered Person, or (4) pregnancy-related expenses of a Dependent daughter.

**Prescription Drugs** - Drugs and medicines that are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the **Prescription Benefit Summary** section for additional information.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

**Preventive Care** - Certain preventive services that are provided in the absence of sickness or injury. See the **Medical Benefit Summary** for further information.

**Prosthetics** - Artificial limbs or eyes required to replace natural limbs or eyes. Post-mastectomy breast prostheses. Coverage is also provided for the necessary replacement or repair of such prosthetics. Benefits for repair costs shall not exceed the cost of replacement.

**Radiation Therapy** - Radium and radioactive isotope therapy.

**Rehabilitation Therapy, Outpatient** - The following therapy services provided on an Outpatient basis:

occupational therapy services by a licensed occupational therapist, which are not related to employment, for restoration or improvement of motion when: (1) recommended as Medically Necessary by a Physician, and (2) due to Sickness or Accidental Injury and the individual had normal body motion prior to the Sickness or Accidental Injury;

physical therapy services by a licensed physical therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function;

speech therapy services by a qualified speech therapist, but only when used to restore or rehabilitate any speech loss or impairment caused by Accidental Injury or Sickness. In the case of a congenital defect that can be corrected or improved with surgery, expenses will be considered only if incurred after surgery for the defect.

NOTES: Speech therapy provided to a child solely due to developmental delay is not covered. For therapy services provided in the patient's home, see "Home Health Care".

**Respiratory Therapy** - Professional services of a licensed respiratory therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

**Second (& 3rd) Surgical Opinion** - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

NOTE: See **Utilization Management Program** for information on when a second opinion may be required. No benefits are payable for a second (or third) opinion for cosmetic surgery, normal obstetrical deliveries, or surgeries which require only a local anesthetic.

**Sterilization Procedures** - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

**Substance Use Disorder Care** – see "Mental Health / Substance Use Disorder Care"

**TMJ** - Procedures to treat temporomandibular joint dysfunction (TMJ), provided the treatment plan is supported by documented clinical evidence.

**Transplants** (Human Tissue) - Services and supplies related to non-investigative organ or tissue transplant for:

a Covered Person who receives the organ or tissue; and

a Covered Person who donates the organ or tissue; and

an organ or tissue donor who is not a Covered Person, if the organ or tissue recipient is a Covered Person. Benefits for such donor will be reduced by any amounts paid or payable by the donor's own coverage(s).

**Urgent Care Facility** - see **Definitions**

**Wigs** - Purchase of one wig for hair loss resulting from chemotherapy or radiation therapy.

NOTE: Other hair restoration services/supplies are not covered. See "Hair Restoration" in the list of **Medical Limitations and Exclusions**.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

# MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

**Abortion** - Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

**Air Purification Units, Etc.** - Air conditioners, air-purification units, humidifiers and electric heating units.

**Biofeedback** - Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

**Cosmetic & Reconstructive Surgery, Etc.** - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

services necessitated by an Accidental Injury;

surgery that is necessary to correct a congenital abnormality in covered Dependent child; or

coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including but not limited to lymph-edemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient.

**Custodial & Maintenance Care** - Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, etc.) that could be rendered at home or by persons without professional skills or training.

Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution;

Any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time, except as may be included as part of a formal Hospice care program;

Residential Care including Wilderness Treatment.

**Dental Care** - Care or treatment on or to the teeth, alveolar processes, gingival tissue, for malocclusion, or orthodontic braces, appliances or services.

Note: This limitation does not apply to Oral Guards when related to Radiation Treatment.

**Diagnostic Hospital Admissions** - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

**Ecological or Environmental Medicine** - Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

**Educational or Vocational Testing or Training** - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

**Exercise Equipment / Health Clubs** - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

**Foot Care, Routine** - Routine and non-surgical foot care services and supplies including, but not limited to:

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

treatment of weak, strained, flat, unstable or unbalanced feet;

orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

**Genetic Counseling or Testing** - Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary for the following:

during the course of a high-risk Pregnancy; or

when patient has been diagnosed and is under current treatment for cancer and the testing is needed to determine a course of treatment; or

under the following guidelines of the United States Preventive Services Task Force (USPSTF):

USPSTF recommends with a "B" Rating that women whose family is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.

**Hair Restoration** - Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

NOTE: The Plan will cover the purchase of a wig for hair loss resulting from medical treatment (i.e., chemotherapy). See "Wigs" in **Eligible Medical Expenses**.

**Hearing Exams & Hearing Aids –** Advanced Vestibular Therapy, Hearing exams, hearing tests, hearing aids or the fitting of hearing aids.

NOTE: This limitation does <u>not</u> apply to routine annual hearing screenings for persons up to age 22.

**Holistic, Homeopathic or Naturopathic Medicine** - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

**Hypnotherapy** - Treatment by hypnotism.

**Impregnation** - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

**Learning & Behavioral Disorders** - Testing or treatment for learning or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, or autism.

**Maintenance Care** - see "Custodial & Maintenance Care"

**Marriage & Family Counseling** - Counseling for the purpose of resolving family or marital difficulties.

**Non-Prescription Drugs and Supplies** - Drugs or supplies for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan.

Drugs or supplies for which there is a non-prescription equivalent available.

**Not Medically Necessary / Not Physician Prescribed** - Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

**Orthognathic Surgery** - Surgery to correct a receding or protruding jaw. However, Plan coverage will be available when the surgery is Medically Necessary.

**Pain Control** - Services or supplies for treatment of chronic, intractable pain by a pain control center or under a pain control program or acupuncture.

**Personal Comfort or Convenience Items** - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas,

whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Note: This limitation does not apply to humidifiers that are built into (or a part of) a CPAP Machine.

**Preventive or Routine Care** - Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

**Psychiatric Testing, Etc.** - Except to the extent coverage is provided under the benefits for mental health care, the Plan does not cover psychiatric or psychological testing or evaluation, unless related to an accidental injury or illness.

**Rehabilitation (Long-Term)** - Long-term rehabilitative, maintenance care or rest cures, including Residential Care facilities and Wilderness Treatment programs.

**Self-Procured Services** - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

**Sex-Related Disorders** - Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies which are not related to organic disease. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

**Smoking Cessation –** Nicotine withdrawal programs, facilities, drugs or supplies, except as specifically included in the *Prescription Benefit Summary* or in the *Appendix for Federally-Required Preventive Care Benefits,* when services/supplies are received from a *network provider.*

**Therapies** - Vocational, educational, recreational, art, dance or music therapy.

**Vision Care** - Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: See “Cataract Surgery” in the **Medical Benefit Summary and Eligible Medical Expenses** sections for coverage information.

**Vitamins or Dietary Supplements** - Prescription or non-prescription organic substances used for nutritional purposes.

**Vocational Testing or Training** - Vocational testing, evaluation, counseling or training.

**Weight Control Measures** - Services, supplies or treatment for obesity, weight reduction or weight gain or prescriptive nutritional supplements, minerals or vitamins.

Surgical procedures to correct obesity, except when all of the following criteria have been met:

the individual is more than 125 pounds over his normal weight, based upon the standard Body Mass Index;

the individual has been diagnosed with another life-threatening condition;

the individual has documentation that non-surgical treatment of the obesity has failed;

the individual is currently under treatment for one of the following conditions:

cardiac disease
diabetes
hypertension
joint pain
sleep apnea

**Wigs or Wig Maintenance** - see "Hair Restoration"

*- (See also **General Exclusions** section) -*

# PRESCRIPTION BENEFIT SUMMARY

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and a prescription program vendor. The following is a summary of the program.

Prescription coverage includes a retail program with participating retail pharmacies and a mail order option. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Plan participants. The mail order option allows a Plan participant to receive a larger quantity of a prescription and is generally useful for long-term or maintenance-type drugs.

When using the program, a Covered Person is required to use his ID card, a Participating Pharmacy (the "retail feature" or the mail-order option) and he must pay a Co-Pay toward each purchase:

## SCHEDULE OF PRESCRIPTION BENEFITS

| **PRESCRIPTION PROGRAM** | **Covered Person Pays** |
|---|---|
| **Retail Pharmacy Feature** (Co-Pays apply "per 1 month supply" of a drug) | |
| Tier 1: Most generic & selected OTC drugs | $5 Co-Pay |
| Tier 2: Brand Name Drug (no generic equivalent) & selected Generic Drugs | $10 Co-Pay |
| Tier 3: Selected Drugs within each therapeutic class | $35 Co-Pay |
| Diabetic Supplies PPO Option (see NOTE) | 20% of contract fee |
| Diabetic Supplies EPO Option | $0 Co-Pay |
| To use the Retail Pharmacy Feature, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A retail prescription can be purchased in up to a 1 month supply for the Co-Pays shown. | |
| NOTE: For individuals with dual coverage under the Plan, the 20% Co-Pay for diabetic supplies can be submitted for reimbursement in accordance with the **Coordination of Benefits** provision of the Plan's medical benefits. | |
| **Mail Order Option** (Co-Pays apply "per 1 month supply" of a drug) | |
| Tier 1: Most generic & selected OTC drugs | $5 Co-Pay |
| Tier 2: Brand Name Drug (no generic equivalent) & selected Generic Drugs | $10 Co-Pay |
| Tier 3: Selected Drugs within each therapeutic class | $35 Co-Pay |
| The Mail Order Option is for maintenance (longer-term) drugs. A mail order prescription can be purchased in up to a 3-month supply (for most maintenance drugs) for the Co-Pays shown. | |

NOTE: The prescription program vendor has a list of formulary (preferred) drugs. That list may be updated and/or amended periodically without notice.

## ELIGIBLE PRESCRIPTION EXPENSES

Eligible Prescription expenses will include:

**Acne Products -** Retin-A for individuals up to age 25

**Alcoholism** - medications used in the treatment of alcoholism

**Bee Sting Kits** and other kits as determined by the Plan

**Compound Medications** of which at least one ingredient is a Prescription Legend Drug. All applicable prescription Co-Pays will apply

**Contraceptives** - birth control devices, including but not limited to diaphragms, and contraceptive medications when prescribed by a Physician

**Diabetic Supplies** – Supplies necessary for monitoring a diabetic condition (such as clinitest or chemstrips for at-home urine testing, including injectable insulin, insulin needles, disposable and non-disposable syringes), and the following supplies: test strips, lancets, lancet devices, pin patches, swabs, and blood glucose monitors and kit;

**Imitrex**

**Non-Injectable** Prescription Legend Drugs (i.e., any medicinal substance whose label is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription")

**Pre-natal vitamins**

**Any other** drugs which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician

## STEP THERAPY PROGRAM

Step therapy programs are designed to ensure that the prescription drug list medication are attempted as a first line therapy before a non-preferred medication is selected. Documentation is obtained from the Covered Person's Physician that two (2) or more medications from the program vendor's prescription drug list have been tried and failed before approval for the step therapy medication is granted. The step therapy program follows nationally-recognized clinical guidelines to ensure the step therapy medications are beneficial for the patient and Plan. The goal of this process is to promote the use of safe and effective medication therapy. This review may be initiated by the pharmacy, the Covered Person or Physician.

## LIMITATIONS AND EXCLUSIONS

Expenses due to the following are not eligible Prescription expenses:

**Blood** - immunological agents, biological sera, blood or blood plasma

**Cosmetic Products** - drugs used for cosmetic purposes (i.e., Retin-A for individuals over age 25)

**Duplicate -** replacement of lost or stolen medications

**Equipment, Devices, Etc** - devices and appliances

**Experimental & Non-FDA Approved Drugs** - experimental or investigational drugs

**Fertility Drugs** - medications used for the treatment of infertility; progesterone suppositories and suspension or any other medication used in the treatment of infertility

**Hair Loss Drugs** - Minoxidil Lotion/ Rogaine or any other medications used in the treatment of hair loss

**Injectables** - (EXCEPT insulin, Imitrex, Bee Sting Kits and those which are preauthorized – see "Preauthorizations" in the ADDITIONAL INFORMATION, below)

**Non-Prescription Drugs** - drugs or medications available without a doctor's prescription

**Vitamins** - prescription and over-the-counter (OTC) vitamins, except for pre-natal vitamins

**Weight Management Drugs -** prescription items which can be used as appetite suppressants

## ADDITIONAL INFORMATION

**Definitions**
When capitalized within the text of this section, the following terms shall have the meanings indicated:

**Participating Pharmacy** - A pharmacy in the prescription vendor's network.

**Prescription** - The request for each separate drug or medication issued by a Physician, and any authorized refill of such request.

All other Plan **Definitions** will apply to benefits provided under this section as well.

**Preauthorizations**
In addition to those expressly covered, injectables may be covered for certain conditions with prior authorization from the Plan. In order for an injectable to be considered for coverage, the prescription must meet the following criteria. It must be:

dispensed by a contracted retail pharmacy
purchased for self-administration
prescribed for approved FDA indications
available only as a 30-day supply
Medically Necessary

NOTE: Preauthorization may also be required for certain other medications.

**Special Assignment Provision**
Benefits for drugs purchased through the prescription drug program will be paid directly to a Participating Pharmacy, provided: (1) the Covered Person authorizes such payment by signing a form furnished by the Participating Pharmacy and satisfactory to the Plan, utilizing a drug ID card, and (2) the Participating Pharmacy accepts the authorization along with payment by the Covered Person of the Co-Pay as full payment for the drugs or medicines for which the benefits are provided. Otherwise, such benefits are not assignable.

**Dispensing Limitations**
A Prescription (walk-in or retail) may be purchased in a 30-day supply. Most maintenance drugs may be obtained in a 90-day supply (mail-order ONLY).

**Drug ID Cards**
By arrangement with the prescription drug vendor, cards will be issued directly to each Employee/Retiree. The card will be required by the Participating Pharmacy for purposes of (1) using this benefit and (2) making any assignment of benefits as stated above.

# GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

**Alcohol** - Any services rendered to a Covered Person arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

**Criminal Activities** - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

**Drugs in Testing Phases** - Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

**Error -** That are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

**Excess Charges** - Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

**Experimental / Investigational Treatment** - Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

expressly included under "**Clinical Trials**" in the list of "*Eligible Medical Expenses*"; or

approval of the U.S. Food and Drug Administration for marketing the drug or device for the specific diagnosis has been given at the time it is furnished, if such approval is required by law; and

reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and

reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

**Forms Completion** - Charges made for the completion of claim forms or for providing supplemental health information, including but not limited to photocopies.

**Government-Operated Facilities** - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

**Illegal Drugs or Medications –** Any services, supplies, care or treatment rendered to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

**Late-Filed Claims** - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

**Military Service** - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

**Missed Appointments** - Expenses incurred for failure to keep a scheduled appointment.

**Negligence** – Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any licensed Physician.

**Never Event** – The presence, manifestation, diagnosis, or treatment of any illness or injury that is determined by the Plan, at their sole discretion, to have been caused by care management, rather than the underlying disease, and includes any error that occurs from failure to follow standard care or institutional practices, and whose causal etiology includes, but is not limited to, any error in medical care that is clearly identifiable, preventable, serious in their consequence to the patient and is adverse, and/or is indicative of a problem in the safety and creditability of a health care facility or provider of service. This term includes, but is not limited to, the following:

- Surgical Events: surgery performed on the wrong body part, surgery performed on the wrong patient, wrong surgical procedure performed on a patient, unintended retention of a foreign object in a patient after surgery, or other procedure intraoperative or immediately postoperative death in a normally health patient.
- Product of Device Events: patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the health care facility, patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended, patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility.
- Patient Protection Events: infant discharged to wrong the person, patient death or serious disability associated with patient leaving the facility without permission, patient suicide, or attempted suicide, resulting in serious disability while being cared for in a health care facility.
- Care Management Events: patient death or serious disability associated with a medical error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration), patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA – incompatible blood or blood products, maternal death or serious disability associated with labor or delivery in a low risk pregnancy while being cared for in a health care facility, patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility, death or serious disability associated with failure to identify and treat hyperbilirubinemia in newborns, stage 3 or 4 pressure ulcers acquired after admission to a health care facility, patient death or serious disability due to spinal manipulative therapy, artificial insemination with the wrong donor's sperm or wrong egg.
- Environmental Events: patient death or serious disability associated with an electric shock while being cared for in a health care facility, any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances, patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility, patient death or serious disability associated with a fall while being care for in a health care facility, patient death or a serious disability associated with the use of restraints or bedrails by being cared for in a health care facility.
- Criminal Events: any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider, abduction of a patient of any age, sexual assault on a patient within or on the grounds of a health care facility, death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a health care facility.

**No Charge / No Legal Requirement to Pay** - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

**Not Listed Services or Supplies** - Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

**Nuclear Energy Release** - Any injury or illness resulting from the non-therapeutic release of nuclear energy.

**Other Coverage** - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

**Outside United States** - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

**Postage, Shipping, Handling Charges, Etc.** - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

**Prior to Effective Date / After Termination Date** - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

**Provider Error** - Services required as a result of unreasonable provider error.

**Relative Care** - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee/Retiree or of the Employee's/Retiree's spouse).

**Telecommunications** - Advice or consultation given by or through any form of telecommunication, unless specifically included in the *Schedule of Benefits* or *Eligible Medical Expenses.*

**Travel** - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

**Unreasonable** – Services that are not “Reasonable,” and are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense that are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

**War or Active Duty** - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

**Work-Related Conditions** - Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain. Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However, if the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

# COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

## DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

**Other Plan** - Any of the following that provides health care benefits or services:

group, blanket or franchise insurance coverage;

group hospital or medical service prepayment plans (HMOs, PPOs, EPOs);

group automobile insurance;

individual auto insurance based upon the principles of "No Fault" coverage;

any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs including Medicare, TRICARE, and any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage;

any group coverage sponsored by or provided through a school or other educational institution.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

The Contract Administrator shall not be required to determine the existence of any Other Plan, or the amount of benefits payable under any Other Plan. The payment of benefits under This Plan shall be affected by the benefits payable under Other Plans only if the Contract Administrator is furnished with information concerning the existence of such Other Plans by the Employer, covered Employee/Retiree, or any other insurance company, organization or person.

**This Plan** - The coverages of this Plan.

**Allowable Expense** - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee 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 and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

**Claim Determination Period** - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

**Custodial Parent** - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

## EFFECT ON BENEFITS UNDER THIS PLAN

**When Other Plan Does Not Contain a COB Provision** - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be its normal liability minus benefits paid or payable by the Other Plan(s).

**When Other Plan Contains a COB Provision** - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay its normal liability minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made on a claim-by-claim basis. No savings or credit reserves will be recognized.

## ORDER OF BENEFIT DETERMINATION RULES

If an “Other Plan” has a COB provision, whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

**Medicare as an "Other Plan"** - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

**Non-Dependent vs. Dependent** - The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

**Child Covered Under More Than One Plan** - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated (whether or not they have ever been married), or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the noncustodial parent; and then

the plan of the spouse of the noncustodial parent.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides for more than half the Calendar Year without regard to any temporary visitation.

**Active vs. Inactive Employee** - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

The plan that covers the Claimant as an active employee or a dependent of an active employee is primary over a plan providing coverage under a right of continuation pursuant to federal or state law (e.g. COBRA). If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

**Longer vs. Shorter Length of Coverage** - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

## OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

**Facility of Payment** - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

**Right of Recovery** - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan 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 Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

# THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

**Payment Condition**

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or Disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

**Subrogation**

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party.
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
    c. Any policy of insurance from any insurance company or guarantor of a third party.
    d. Workers' compensation or other liability insurance company.
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

**Right of Reimbursement**

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or Disability.

**Participant is a Trustee Over Plan Assets**

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

    a. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

**Excess Insurance**

If at the time of Injury, Sickness, Disease or Disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

**Separation of Funds**

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(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.

**Wrongful Death**

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

**Obligations**

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, Disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
    h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

**Offset**

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

**Minor Status**

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

**Language Interpretation**

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

**Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

# ELIGIBILITY AND EFFECTIVE DATES

**Choice of Coverage & Annual Election**
The medical coverages of the Plan include optional schedules from which an Employee/Retiree chooses at point of initial enrollment in the Plan. An Employee/Retiree must enroll himself and his Dependents (if any are to be enrolled) in the same option(s).

During the month of October of each Plan Year, covered Employees, covered Retirees and their covered Dependents may change among the medical coverage options offered by the Employer. Open Enrollment changes will be effective January 1st following such election.

Any benefits paid while an individual was covered under one option will be carried forward and applied against the benefits maximums of the newly-elected option.

**Eligibility & Effective Dates - Employees**
Eligibility Requirements - In order to be eligible to participate in the health coverages of the Plan, an Employee must be in active full-time (non-temporary) employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work based on the bargaining contract.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day he is absent from work during an approved FMLA leave or other paid leave, or solely due to his own ill health.

Coverage Effective Date - An Employee's coverage is effective on the first of the month following his first day of "active employment" in an eligible status.

When "active employment" begins on the first day of a calendar month, coverage is effective immediately.

NOTE: Coverage is never automatic. Enrollment forms for all persons MUST be completed at the District Insurance Office within 31 days of eligibility date.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

**Eligibility & Effective Dates - Retirees**
A Board-approved Employee with ten (10) or more years of consecutive service with the Employer who retires at age 55 or older, and an Employee on an approved disability retirement with fifteen (15) or more years of consecutive service and who is age 50 or older, may continue Plan coverage (medical only) as a "Retiree" until the Retiree attains age 65.

The eligible employee must be in a benefited status at the time of his retirement in order to qualify for this benefit. Application for this continued coverage must be completed and filed with the District Insurance Office.

Retirees have the option of choosing medical coverage for themselves only or to also cover a spouse or state-registered domestic partner – see "Eligibility Requirements – Dependents", below. Each level of coverage requires a yearly contribution as shown in the "Funding Sources and Uses" provision in the General Plan Information section.

The disability retirement may be considered for up to 12 months before approval. Under this circumstance the Employee and any enrolled Dependent(s) would be eligible to continue benefits on an "active" basis until a final determination has been confirmed. Upon approval, the Retiree's coverage Effective Date will be adjusted accordingly and applicable coverage costs will be due and payable to the Plan.

**Eligibility & Effective Date - Dependents**
Eligibility Requirements - An eligible Dependent of an Employee is:

a legally married spouse. "Legally married" means a legal union (as defined by the Employee's state of residence) between two individuals. An eligible spouse will not include a common law spouse;

a registered domestic partner when the partner and Employee have registered their domestic partnership with the Secretary of State of the State of California. The State of California permits state registration of: (1) same-sex domestic partnerships, and (2) opposite-sex partnerships after one partner attains age 62. A domestic partnership registration from outside of California will be recognized on the same basis as a California state-registered domestic partnership only if the out-of-California partnership is a legal union of two persons of the

same sex, other than a marriage, and is substantially equivalent to a registered California domestic partnership. This applies regardless of whether it bears the name "domestic partnership," Domestic partners who register only with their cities, counties or employers are not eligible;

a child who is under age 26 (i.e., up to but not including the child's 26th birthday). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee, (4) be unmarried, or (5) be unemployed. An eligible Dependent child will include:

- a natural child;
- a stepchild;
- a child placed under the legal guardianship of the Employee;
- a child who is adopted by the Employee or placed with him for adoption;
- a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements of ERISA (section 609(a)).

Because this is a non-grandfathered plan, the Plan cannot refuse dependent coverage to an adult child, even if they are eligible for their own employer-sponsored group health coverage.

NOTES: An eligible Dependent does not include:

a spouse following legal separation or a final decree of dissolution or divorce;

a domestic partner following the automatic termination of the Domestic Partnership 6 months after the filing of a Notice of Termination of Domestic Partnership with the Secretary of State of the State of California. The termination of a domestic partnership will be treated as equivalent to a divorce between a husband and wife;

any spouse or domestic partner who is on active duty in a military service, to the extent permitted by law.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - All Dependents, except adoptive children, shall have coverage effective on the first of the month following the date they become eligible. A Dependent's coverage will not become effective prior to the Employee's/Retiree's coverage effective date.

**NOTE: Coverage is never automatic. Enrollment forms for all persons MUST be completed at the District Insurance Office within thirty-one (31) days of the Dependent's eligibility date.**

Newborn and Adoptive Children - A Dependent child born after the effective date of Employee's coverage is eligible and covered from birth. However, the Plan Sponsor and Contract Administrator must be notified of the birth and the child must be properly enrolled within thirty-one (31) days of birth.

An adoptive child who is placed with the Employee within thirty-one (31) days of birth will be covered from birth. Any other adoptive child will be covered from the date the child is adopted by the Employee or the date he is placed with the Employee for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.

**Reinstatement / Rehire**

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated (for himself and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires. No waiting period requirement will be applied.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

**Dual Coverage**
When a husband and wife are both enrolled as Employees or Retirees, each has the option to enroll eligible Dependents for coverage hereunder. The combined maximum Plan benefits shall not exceed the aggregate of 100 percent of the Allowable Amount(s) for the Eligible Expense(s).

**Transfer of Coverage**
If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

# TERMINATION OF COVERAGE

**Employee / Retiree Coverage Termination**
Except as noted, an Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan benefits as described herein;

termination of participation in the Plan by the Employee/Retiree;

the end of the period for which Employee / Retiree last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

the date the Employee dies (see note below regarding dependent termination date).

NOTE: An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

**Dependent Coverage Termination**
Except as noted, a Dependent's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee/Retiree;

at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

NOTES: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent termination due to Employee death will be at midnight of the last day of the month in which the Employee dies.

- *(See **COBRA Continuation Coverage**)* -

# EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

**Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children**
If a covered Dependent child attains the age that would otherwise terminate his status as a "Dependent," and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

**Extensions of Coverage During Absence From Work**
If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, or is eligible for an extension required by law, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except where the Family and Medical Leave Act (FMLA) may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

on the date coverage terminates as specified in the Employer's written personnel policies and employee communications. Such documents are incorporated herein by reference;

the date the person becomes covered under any other group plan for benefits of a type similar to those provided by this Plan;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of the Plan or these benefits of the Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition;

Employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the National Guard and Reserves and certain retired military in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered servicemember. A "covered servicemember" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform his or her duties).

**Extension of Coverage During U.S. Military Service**
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

24 months; or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

An employee returning from military leave must notify their employer of their intent to return to work. Notification (application for reemployment) must be made:

within 14 days after active military service ceases for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

No reemployment application is required if the military leave is less than 31 days. In that case, generally the employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an injury or illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage hereunder is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

**Extension of Coverage for Retirees** - see **Eligibility and Effective Dates** section.

- *(See **COBRA Continuation Coverage**) –*

# EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If an Employee or Dependent is Totally Disabled on the date he becomes ineligible for coverage or continuation under COBRA, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

upon termination of the Total Disability;

twelve (12) months following the date coverage terminated;

upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition;

upon termination of the Plan.

With reference to an Employee, "Total Disability" or "Totally Disabled" means a disability resulting solely from a sickness, injury or pregnancy that prevents the Employee from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training, or experience. Employee may not, in fact, be engaged in any employment or occupation for wage or profit and be considered Totally Disabled. For a Dependent, it is disability that prevents Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

*- (See **COBRA Continuation Coverage**) -*

# CLAIMS PROCEDURES

## SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

   **Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.**

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time.

   Written proof covering the details of loss for which a health care claim is made must be furnished to the Contract Administrator within one (1) year of the date on which the expenses were incurred. Bills submitted after one (1) year will not be honored.

   A Post-Service Claim should be submitted as follows:

   Claims incurred in California to:

   **Anthem Blue Cross Prudent Buyer**
   P. O. Box 60007
   Los Angeles, CA 90060-0007

   Claims incurred outside of California to:

   **The local Blue Cross/Blue Shield Association**
   Claims are to be submitted by the provider. If a provider is unable to submit a claim, contact the Contract Administrator, EBA&M, for assistance at (800) 249-8440**.**

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

## ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be

subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

## CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.).

To the extent the Plan is established and maintained pursuant to a collective bargaining agreement and if the bargaining agreement sets forth or incorporates by reference: (1) provisions concerning the filing of claims and the initial disposition of claims, and (2) a grievance and arbitration procedure to which adverse benefit determinations are subject, then the terms of the bargaining agreement will apply to claims handlings. However, if the bargaining agreement includes only a grievance and arbitration procedure, then the provisions included herein concerning the filing and initial disposition of claims will apply but the appeal procedures will be superceded by the terms of the bargaining agreement.

**Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.**

| **"PRE-SERVICE" CLAIM ACTIVITY** | **TIME LIMIT OR ALLOWANCE** |
|---|---|
| **Urgent Claim** - defined below | |
| Claimant Makes Initial Incomplete Claim Request | Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice. |
| Plan Receives Completing Information | Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information. |
| Claimant Makes Initial Complete Claim Request | Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination. |
| Claimant Appeals | See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing. |
| Plan Responds to Appeal | Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal. |

An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.

Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, considering the urgency of the medical situation.

| **"PRE-SERVICE" CLAIM ACTIVITY** | **TIME LIMIT OR ALLOWANCE** |
|---|---|
| **Concurrent Care Claim** - defined below | |
| Plan Wants to Reduce or Terminate Already Approved Care | Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules. |
| Claimant Requests Extension for Urgent Care | Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. |
| A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination. | |
| **Non-Urgent Claim** | |
| Claimant Makes Initial Incomplete Claim Request | Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification. |
| Plan Receives Completing Information | Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. |
| Claimant Makes Initial Complete Claim Request | Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. |
| Claimant Appeals | See "Appeal Procedures" subsection. |
| Plan Responds to Appeal | Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal). |
| "Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period. | |

| **"POST-SERVICE" CLAIM ACTIVITY** | **TIME LIMIT OR ALLOWANCE** |
|---|---|
| Claimant Makes Initial Incomplete Claim Request | Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request. |
| Plan Receives Completing Information | Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. |
| Claimant Makes Initial Complete Claim Request | Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. |
| Claimant Appeals | See "Appeals Procedures" subsection. |

| | |
|---|---|
| Plan Responds to Appeal | Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels). |

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.

**Authorized Representative May Act for Claimant**
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

**Written or Electronic Notices**
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

**Full and Fair Review**
During the internal claims and review process, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

During the internal claims and appeals process, the Claimant may review the claim file and present evidence and testimony as part of the process. The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan, or new rationale used in making its determination in connection with the claim, sufficiently in advance of the notice of Final Internal Adverse Benefit Determination in order to give the Claimant a reasonable opportunity to respond prior to that date.

## ADVERSE BENEFIT DETERMINATIONS

If a claim is wholly or partially denied, or there is a reduction, or termination of, or a failure to provide or make payment for (in whole or in part), a benefit, or a rescission of coverage (as defined in Treas. Reg. § 54.9815-2712T) whether or not there is an adverse impact on a claim or benefit, the individual will be given written or electronic notification of such determination within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

date of service, provider, and claim amount (if applicable)

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Adverse Benefit Determination;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims, including a statement of the individual's right to bring a civil action under section 502(a) of ERISA.

Effective July 1, 2011 or such later date pursuant to guidance issued by the Department of Labor, any notice of Adverse Benefit Determination will be provided in a culturally and linguistically appropriate manner and include:

name of health care provider

the diagnosis code and its corresponding meaning

the treatment code and its corresponding meaning

the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination including the denial code and corresponding meaning

a description of the Plan's standard, if any, used in denying the claim and, with respect to a Final Internal Adverse Benefit Determination, a discussion of the decision

a description of available internal appeals and external review processes

disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with the Internal Claims and Appeals and External Review processes.

## INTERNAL APPEAL PROCEDURES

**Filing an Internal Appeal**
Within 180 days of receiving notice of an Adverse Benefit Determination, an individual may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal.

**Deemed Exhaustion of Internal Claims and Appeals Process**
Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures. Effective July 1, 2011, in the event the Plan fails to strictly adhere to all the requirements of the internal claims and appeals procedures with respect to a claim, the Claimant may initiate an External Review or pursue any available remedies under ERISA 502(a) or State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

**Decision on Internal Appeal**
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a); and

information about the external appeals process.

A Plan participant and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact the Local U.S. Department of Labor Office and the State insurance regulatory agency.

**Any New Evidence During the Appeal Process**
If any new evidence is considered, relied upon or is generated during the appeal process, or a determination is based on a new rationale, the Claimant must be furnished with the new evidence or rationale as soon as possible and free of charge. This documentation must be provided sufficiently in advance of the final determination so that the Claimant has a reasonable opportunity to respond before the final determination is made.

**Avoidance of Conflicts of Interest**
Claims and appeals will be adjudicated by individuals who are independent and impartial. This means that the fiduciary deciding an appeal will be different from (and not subordinate to) the individual who decided the initial claim, and that any medical expert consulted regarding an appeal will be different from (and not subordinate to) the expert consulted in connection with the initial claim. Moreover, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert cannot be based upon the likelihood such individual will deny a claim.

**Continued Coverage Pending Appeals Outcome**
Coverage must continue during the appeal process, pending the outcome of the review. This requirement is intended to be consistent with current ERISA regulations for claims involving concurrent care (i.e., where the Plan has previously approved an ongoing course of treatment for a specified period of time or number of treatments, it cannot reduce the period/number without first providing the Claimant advance notice and an opportunity to appeal).

## EXTERNAL REVIEW PROCEDURES

**Filing an External Review**
An individual may file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt (e.g. February 28), the request must be filed by the first day of the fifth month following receipt of the notice. The request is filed as described in the notice.

**Preliminary Review**
Within five (5) business days after the date of the receipt of the external review request, a preliminary review must be completed to determine whether:

the Claimant is or was covered by the Plan at the time the health care service was requested;

the Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

the Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeals process; and

the Claimant has provided all of the information and forms required to process an external review.

Within one (1) business day after completing the preliminary review, a written notification must be issued to the Claimant. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefit Security Administration (EBSA).

If the request is not complete, the notification must describe the information needed to make the request complete, and the Plan must let a Claimant perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

**External Review Process**
The external review process is independent and without bias and may be assigned to and conducted by an independent review organization (an "IRO") that is accredited by a nationally recognized accrediting organization or may be conducted in another manner that ensures an independent and unbiased external review. If an IRO will be assigned to conduct the review, then at least three IROs must be under contract for assignments which must be rotated among them. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO shall notify the Claimant, in a timely manner, of its acceptance of the review and inform the Claimant of the deadlines for submissions of additional information which shall be no later than ten business days following receipt of this notice.

Within five business days of assignment of the external review to the IRO, the Plan shall provide to the IRO any documents and information it used in making its Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

**Notice of Final Review Decision**
The IRO must provide written notice of the Final External Review Decision within 45 days after receiving the request for the external review. The notice must be delivered to the Claimant and to the Plan.

**Expedited External Review**
External review procedures may be expedited for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize his or her ability to regain maximum function , an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility. For an expedited review, the IRO must provide notice of the Final External Review Decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice to the Claimant is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the Claimant and the Plan.

# DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

**Accidental Injury** - Any accidental bodily injury caused by external forces under unexpected circumstances and which does not arise out of or in the course of the employment of a Covered Person. Accidental Injury does not include illness or infection, except infection of a cut or wound. Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination. Self-inflicted illness or injury will not be considered Accidental Injury for purposes of benefit determination.

**Allowable Amount** - The Allowable Amount is:

the amount the Plan has determined is an appropriate Eligible Expense for the services rendered in the provider's geographic area, based upon such factors as the Plan's evaluation of the value of the services related to the value of other services, market considerations, and provider charge patterns; or

such other amount as the provider and the Plan have agreed will be accepted as payment for the services rendered; or

the amount the Plan determines is appropriate (if an amount is not determined as described in either of the above), considering the particular circumstance and the services rendered;

10% of the charge for the primary surgeon for the necessary use of an RN Surgery Assistant.

**Ambulatory Surgical Center** - Any public or private establishment that:

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

does not provide services or other accommodations for patients to stay overnight.

**Benefit Document** - A document that describes one (1) or more benefits of the Plan.

**Birthing Center** - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

has organized facilities for birth services on its premises;

provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

has 24-hour-a-day registered nursing services;

maintains daily clinical records.

**Calendar Year** - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

**Claimant** - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

**Contract Administrator** - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

**Convalescent Hospital** - see "Extended Care Facility"

**Coordination of Benefits (COB)** – see **Coordination of Benefits (COB)** section

**Covered Person** - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee/Retiree, a covered Dependent, a Qualified Beneficiary (COBRA), etc.). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

**Covered Provider** - An individual who is:

licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of his license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

Audiologist*
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Dental Hygienist - when practicing under the direction and supervision of a Dentist
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Marriage Family and Child Counselor (MFCC)
Nurse Practitioner
Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)*
Physician - see definition of "Physician"
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychologist (PhD or EdD)
RN Surgery Assistant - when requested by the surgeon and the procedure indicates the need for assistant services (Eligible Expense is limited to 10% of the charge for the primary surgeon)
Registered Nurse (RN)
Respiratory Therapist
Speech Therapist*

(providers which are asterisked (*) are covered only upon referral by an MD or DO – see “Physician”)

A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered by the Plan:

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;

licensed Outpatient mental health facilities;

freestanding public health facilities;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

**Custodial Care** - Services (including room and board) or supplies provided to a person which consists primarily of basic care given to maintain life and/or comfort with no reasonable expectation of cure or improvement of the injury or illness and which can generally be provided by an individual without special training.

**Dependent** - see **Eligibility and Effective Dates** section

**Eligible Expense(s)** - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

**Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

serious impairment to bodily functions;

serious dysfunction of any bodily organ or part.

**Emergency Services -** Services required for a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in permanent physical impairment or loss of life.

**Employee** - see **Eligibility and Effective Dates** section

**Employer(s)** - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

**Extended Care Facility** - An institution which:

is duly licensed as a Convalescent Hospital, Extended Care Facility, Skilled Nursing Facility, or Intermediate Care Facility and is operated in accordance with the governing laws and regulations;

is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons;

is under the full-time supervision of a Physician or a registered nurse;

admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician;

has established methods and procedures for the dispensing and administering of drugs;

has an effective utilization review plan;

is approved and licensed by Medicare;

has a written transfer agreement in effect with one or more hospitals; and,

is not, other than incidentally, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, for the care of senile persons, a nursing home, a

hotel, a school or a similar institution.

**Fiduciary** - Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

**Home Health Care Agency** - An agency or organization that:

is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;

has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

provides for full-time supervision of its services by a Physician or by a registered nurse;

maintains a complete medical record on each patient;

has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

**Hospice** or **Hospice Agency** - An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

**Hospital** - An institution that:

is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five (5) or more such patients;

has a Physician in regular attendance 24 hours-a-day;

continuously provides 24-hour-a-day nursing service by registered nurses;

maintains a daily medical record for each patient;

maintains facilities for diagnosis of injury or disease;

maintains permanent facilities for major surgical operations on its premises – see NOTE; and

is not, other than incidentally: a place of rest, for custodial care, for the aged, for drug addicts or alcoholics, or for the care of senile persons; a nursing home; a hotel; a school or a similar institution.

NOTE: The requirement for major surgical facilities will be waived for an acute psychiatric hospital which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals.

**Inpatient** - A person physically occupying a room and being charged for room and board in a facility (Hospital, Extended Care Facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

**Intensive Care Unit** (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

**Lifetime** - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

**Medically Necessary** - Any health care treatment, service or supply determined by the Contract Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury or a covered mental health condition or covered substance use disorder;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and

it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

**Medicare** - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, and as amended from time to time.

**Outpatient** - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

**Participating Employer** - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

**Physician** - A Doctor of Medicine, (MD), or Doctor of Osteopathy, (DO), who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

**Plan** - The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

**Plan Document** - A formal written document that describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

**Plan Sponsor** - The entity sponsoring the Plan. See **General Plan Information** section for further information.

**Pregnancy** - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See “Pregnancy Care” in the list of **Eligible Medical Expenses** for further information.

**Rehabilitation Center** - A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

carries out its stated purpose under all relevant state and local laws; or

is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or

is approved for its stated purpose by Medicare.

**Retiree** - see **Eligibility and Effective Dates** section

**Semi-Private Room Charge** - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

**Sickness** - Bodily illness or disease (including covered mental health conditions and covered substance use disorders), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician or other appropriate Covered Provider in order to be considered a Sickness hereunder.

**Urgent Care Facility** - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

**Usual, Customary, and Reasonable (UCR)** - In the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

For any covered services or supply, for non-participating Providers, the Plan will recognize 200% of the CMS National Fee Schedule as the eligible expense. If the actual charge is less than the eligible expense, the actual charge will be the allowance.

# GENERAL PLAN INFORMATION

| | |
|---|---|
| **Plan Sponsor:** | **Garden Grove Unified School District** |
| Address: | 10331 Stanford Avenue<br>Garden Grove, CA 92840 |
| Business Phone Number: | (714) 663-6523 |
| **Name of Plan:** | **Garden Grove Unified School District Self-Insured Health Plan** |
| **Plan Year:** | **January 1 through December 31** |
| **Plan Benefits:** | **Medical Benefits** |
| **Annual Re-Election Period:** | **October** |
| **Contract Administrator:** | **EBA&M** |
| Billing Address: | P.O. Box 5079<br>Westlake Village, CA 91359 |
| Phone: | (800) 249-8440 |
| Facsimile: | (714) 546-0141 |

## FUNDING - SOURCES AND USES

**Contributions**
Active Employees - Active Employees have an option of those family members to be covered under the Plan. Each level of coverage requires a yearly contribution made through ten (10) equal monthly payroll deductions, as indicated below:

- Coverage for the EMPLOYEE ONLY = $500 yearly ($50 x 10 months)
- Coverage for the EMPLOYEE and 1 DEPENDENT = $1,000 yearly ($100 x 10 months)
- Coverage for the EMPLOYEE and 2 OR MORE DEPENDENTS = $1,500 yearly ($150 x 10 months)

Retirees - A Retiree has the option to cover himself only or himself and his spouse. Each level of coverage requires a yearly contribution, as indicated below. A Retiree will be billed for the annual contribution in two (2) installments. The first installment is due and payable on January 1 and the second is due and payable on July 1.

- Coverage for the RETIREE ONLY = $450 yearly
- Coverage for the RETIREE and SPOUSE = $900 yearly

**Employee & Employer Obligations**
Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (NonCOBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **COBRA Continuation Coverage** section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

**Insurance Policy(ies)**
Contributions may be used to purchase insurance coverage(s) to ensure that the Plan will meet its self-funded obligations. The policy(ies) may be reviewed upon request submitted to the Plan Sponsor. The Plan Sponsor is also available to answer any questions about the coverages. The provisions of the Benefit Document in no way modify those of any insurance policy.

**Administration Expenses**
Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

**Taxes**
Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions that are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner that is consistent with applicable law.

## ADMINISTRATIVE PROVISIONS

**Administration (type of)**
Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

**Alternative Care**
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

**Amendment or Termination of the Plan**
Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

determine eligibility for benefits or to construe the terms of the Plan;

reduce, modify or terminate retiree health care benefits under the Plan, if any;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or applicable law; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

**Anticipation, Alienation, Sale or Transfer**
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

**Clerical Error**
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

**Discrepancies**
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

**Entire Contract**
The Benefit Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

**Facility of Payment**
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

**Fiduciary Responsibility, Authority and Discretion**
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization review organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan.

However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

**Force Majeure**
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

**Gender and Number**
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

**Illegality of Particular Provision**
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

**Indemnification**
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

**Legal Actions**
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

**Loss of Benefits**
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

an employee's cessation of active service for the employer;

a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;

a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan.

**Material Modification**
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those that would be construed by the average Plan participant as being "important" reductions in coverage.

**Misstatement / Misrepresentation**
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual on an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

**Misuse of Identification Card**
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

**Non-Discrimination Due to Health Status**
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
claims experience
receipt of health care
medical history
evidence of insurability
disability
genetic information

**Physical Examination**
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

**Plan Administrator Discretion & Authority**
The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the terms of its authority on behalf of the Plan) shall make determinations regarding Plan benefits.

**Privacy Rules & Security Standards & Intent to Comply**
To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

**Purpose of the Plan**
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

**Reimbursements**
Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

**Rescission of Coverage**
The Plan may not rescind an individual's coverage under the Plan (e.g., cancelling coverage after a Covered Person has submitted a claim). However, the Plan may rescind coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact. Failure to provide timely notice of loss of eligibility will be considered intentional representation.

**Rights Against the Plan Sponsor or Employer**
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

**Termination for Fraud**
An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

**Titles or Headings**
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

**Type of Plan**
This Plan is not a plan of insurance. This Plan is a nonfederal governmental group health plan that is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). A nonfederal government employer that provides self-funded group health coverage to its employees may elect to exempt its Plan from most of the requirements of Title XXVII of the Public Health Services (PHS) Act.

Title XXVII was added to the PHS Act by Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and has been amended by the Newborns' and Mothers' Health Protection Act of 1996, the Mental Health Parity Act of 1996, the Women's Health and Cancer Rights Act of 1998, The Genetic Information Non-discrimination Act of 2008 (GINA) and the Children's Health Insurance Program Reauthorization Act of 2009.

With the exception of requirements pertaining to the certification and disclosure of an individual's creditable coverage under the Plan, and GINA requirements, the sponsor of a self-funded nonfederal governmental plan is permitted to exempt the Plan from the requirements of Title XXVII. However, to be exempt, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, the Plan intends to fully comply with federal laws that are applicable to the Plan.

**Workers' Compensation**
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

# COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce, loss of Dependent child eligibility, etc.), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

**Definitions** - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

**Notification** - If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the Employer's "COBRA General Notice" or "Initial Notice" for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

**Election and Election Period** - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

**Effective Date of Coverage** - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

**Level of Benefits** - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible

is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

**Cost of Continuation Coverage** - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

the cost previously charged was less than the maximum permitted by law;

the increase is due to a rate increase at Plan renewal;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

**Maximum Coverage Periods** - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

**Disability Extension** - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

**Termination of Continuation Coverage** - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

**Conversion** - If the Plan Sponsor offers a conversion privilege to NonCOBRA Beneficiaries and in conjunction with the health benefits of the Plan, then a Qualified Beneficiary has the right to exercise the conversion option when he reaches the end of his COBRA continuation coverage.

The option to enroll in the conversion health plan must be given within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the cost of COBRA coverage or the cost of Plan coverage. Also, the conversion policy may provide a lower level of coverage.

The conversion option is not available if the Qualified Beneficiary terminates COBRA coverage before reaching the end of the maximum period of COBRA coverage.

# COBRA NOTICE REQUIREMENTS FOR PLAN PARTICIPANTS

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is:

a Dependent child's ceasing to be eligible (e.g., due to reaching the maximum age limit);

the divorce or legal separation of the Employee from his/her spouse;

the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to **COBRA Continuation Coverage** with a maximum duration of 18 (or 29) months;

where a Qualified Beneficiary entitled to receive **COBRA Continuation Coverage** with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled in the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

It is also important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date the document was prepared and a Qualified Beneficiary should make certain that procedure changes have not occurred before relying on this information. The most current information should be included in the Employer's COBRA Initial General Notice that is provided to new hires.

Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

**Form, Content & Delivery** - Notification of the Qualifying Event must be made to the District Insurance Department. Verbal or written notice that an event has occurred is acceptable.

Upon receipt of the notification, the District Insurance Department will send a change request form by U.S. Mail. The completed form is to be returned to the Insurance Department together with documentation of the Qualifying Event (e.g., a copy of the divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

**Time Requirements for Notification** - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

# ARBITATION AGREEMENT – BINDING ARBITRATION

Sometimes disputes or disagreements may arise between Covered Persons and Garden Grove Unified School District (GGUSD) regarding the construction, interpretation, performance or breach of this Benefit Document, or regarding other matters relating to or arising out of this Benefit Document. GGUSD uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. In addition, disputes with GGUSD involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition of enrolling in the GGUSD medical plan, Covered Persons agree to submit all disputes they may have with GGUSD to final and binding arbitration. GGUSD also agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Covered Persons and GGUSD are bound to use binding arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they have to a jury trial on such disputes. However, no remedies that otherwise would be available to the parties in a court of law will be forfeited by virtue of this agreement to use and be bound by GGUSD's binding arbitration process.

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

GGUSD's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less ($50,000 or less with respect to disputes with GGUSD involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to GGUSD, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000 or $50,000, whichever is applicable. In the event that the total amount of damages is over $200,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to GGUSD, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then any party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. Arbitration can be initiated by submitting a demand for arbitration to GGUSD at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

GARDEN GROVE USD
Attention: Litigation Administrator
10331 Stanford Avenue
Garden Grove, CA 92840

*OR*

EBA&M Corporation
P.O. Box 5079
Westlake Village, CA 91359

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Benefit Document, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Effective July 1, 2002, Covered Persons who are enrolled in an employer's plan that is subject to the PHSA (Public Health Service Act) a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by GGUSD to mandatory binding arbitration. Under PHSA, an "adverse benefit determination" means a decision by GGUSD to deny, reduce, terminate or not pay for all or a part of a benefit.

However, the Covered Person and GGUSD may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

# ADOPTION OF THE BENEFIT DOCUMENT

**Adoption**
The Plan Sponsor hereby adopts this Benefit Document on the date shown below. This Benefit Document replaces any and all prior statements of the Plan benefits that are described herein.

**Purpose of the Plan**
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

**Conformity with Law**
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

**Participating Employers**
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

**Acceptance of the Benefit Document**
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2017.

**Garden Grove Unified School District**

By: _____

Title: _____