

THE EDCARE GROUP

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

MEDICAL AND PRESCRIPTION BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE “EDCARE GROUP HEALTH BENEFITS PLAN”

RESTATED EFFECTIVE: JANUARY 1, 2023

Contract Administrator:

Delta Health Systems
Stockton, California

INTRODUCTION

This is a comprehensive description of our employee medical and prescription coverages which are in effect as of **January 1, 2023**. The EdCare Group is pleased to be able to offer this coverage to you and your eligible dependents.

This document is both the health care Benefit Document and Summary Plan Description except as the document may be subsequently amended. Notice of any amendments will be provided to you as they are adopted.

The Plan benefits described herein are established on a self-funded basis with The EdCare Group assuming all liability for payment of fees and claims. The benefits described herein are not guaranteed and can be modified or terminated at any time. No agent, other than the Plan Administrator (The EdCare Group) has the authority to change the benefits of the Plan or to waive any of its provisions.

Please review this document carefully. Because the coverages of our Plan are self-funded, the Plan's success is dependent upon our wise choice and use of health care services. With medical costs always on the rise, cost-conscious use of medical care will better assure our ability to continue to offer quality health care coverage to our valuable District employees and their families.

In particular, we call the following items to your attention:

- Our Plan includes a **Utilization Management Program**. To assure that you receive the maximum Plan benefits, make certain that you have read and understood the requirements of this program. The organization administering the program is:

WellPoint Life Insurance Company
Phone: (800) 274-7767

- This Plan also includes a provider Network. Generally, Network providers have agreed to render services to Covered Persons at reduced rates. See the **Medical Benefit Summary** for benefit enhancements that may be available when Network providers are used.
- Claims are handled by a Contract Administrator. Review the section entitled **Claims Procedures** and send claims to:

Delta Health Systems
1234 W. Oak Street
P. O. Box 527
Stockton, CA 95201-527
(209) 948-8483 or (800) 422-6099

The Contract Administrator's office should also be contacted if you need additional information about Plan coverage for a specific drug, treatment, procedure, preventive service, etc. No charge will be made for the information.

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Legal Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of 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.

Notice Regarding Disability - Notice that: (a) 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 at any time during 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.

Notice Regarding Address Changes – It is 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. 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 & Means of Notification - Notification of the Qualifying Event must be made on Delta Health Systems' form entitled "Notification of a COBRA Qualifying Event or Social Security Disability." The form is included in the Group Health Insurance Initial COBRA Notification packet. Extra forms can be obtained from Delta, without charge. Call Delta at 800-422-6099 to request a form or for answers to any questions.

After the form is completed, a copy should be made for the Employee's or Qualified Beneficiary's records.

In addition to the completed form, notification must include proof of the event (e.g., a copy of the divorce decree, a copy of the child's birth certificate, a copy of the Social Security Administration's disability determination letter). Attach the proof to the COBRA form and mail to:

Delta Health Systems
Eligibility Department
P.O. Box 1147
Stockton, CA 95201-1147

Call Delta within ten (10) days after the notice is mailed to ensure that it has been received.

Time Requirements for Notification - Should an event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee or family member must provide Notice to the designated recipient with a certain time frame

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

COBRA NOTIFICATION PROCEDURES, continued

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.

TABLE OF CONTENTS

| | Page |
|--|-------------|
| IMPORTANT INFORMATION | 1 |
| UTILIZATION MANAGEMENT PROGRAM | 3 |
| SELF-AUDIT PROGRAM | 4 |
| MEDICAL BENEFIT SUMMARY | 5 |
| ELIGIBLE MEDICAL EXPENSES | 18 |
| MEDICAL LIMITATIONS AND EXCLUSIONS | 25 |
| GENERAL EXCLUSIONS | 29 |
| COORDINATION OF BENEFITS (COB) | 32 |
| SUBROGATION, THIRD PARTY RECOVERY AND REIMBURSEMENT | 35 |
| ELIGIBILITY AND EFFECTIVE DATES | 40 |
| TERMINATION OF COVERAGE | 45 |
| EXTENSIONS OF COVERAGE | 46 |
| EXTENSION OF BENEFITS DURING AN EMPLOYEE'S TOTAL DISABILITY | 49 |
| CLAIMS PROCEDURES | 50 |
| DEFINITIONS | 56 |
| GENERAL PLAN INFORMATION | 64 |
| COBRA CONTINUATION COVERAGE | 74 |
| NOTICE TO TERMINATE EMPLOYEES IN CALIFORNIA | 80 |

IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan 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.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

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).

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

Under Federal law, group health plans that already provide coverage for mental health conditions and/or substance addictions (referred to in the law as “substance use disorders”) must provide coverage for such covered conditions in the same manner as coverage is provided for Sickness. This law applies to group health plans on their Plan Year anniversary beginning on or after October 3, 2009.

NOTE: The Plan is not required to provide coverage for mental health conditions or substance use disorders. Also, the Plan (and not the Act) determines what will be a covered mental health condition and/or a covered substance use disorder. This legislation does not apply to employers with fewer than 51 employees.

GENETIC INFORMATION AND NON-DISCRIMINATION ACT

GINA (Genetic Information and Non-discrimination Act) was enacted on May 21, 2008 and applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan’s eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered employees and their families.

The Act defines genetic information as that obtained from an individual’s genetic test results, as well as genetic test

results of family members and the occurrence of a disease or disorder in family members.

FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND THE CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT

Effective March 18, 2020, as required by The Families First Coronavirus Response Act (“FFCRA”) and the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”), the Plan provides coverage related to the administration, evaluation and testing of COVID-19 with no out of pocket cost to participants of the Plan for services obtained In-Network or Out-of-Network, to the extent required by applicable law. This coverage expires at the end of the Emergency Period as defined in FFCRA. The Plan will comply with any subsequent reinstatement of these provisions as required by these laws.

Coverage includes:

- Physician office and telephonic visits, urgent care visits and emergency room visits;
- In-vitro testing ordered by the individual’s attending provider that are approved by a government agency or emergency authorization from the Food and Drug Administration is pending, or without provider orders to the extent required by law;
- Other tests that the individual’s attending provider conducts during the visit to determine the need for COVID-19 testing and that results in a COVID-19 test being ordered;
- Waiver of penalty for failing to notify the Contract Administrator when obtaining services from Out-of-Network providers;
- Payment for testing for Out-of-Network providers for testing is based on the cash price published by the provider or the amount negotiated between the Plan and provider; and
- Qualifying coronavirus preventive services, which includes COVID-19 immunizations approved or authorized by the FDA, to the extent required by law.

NO SURPRISES ACT

Effective with the plan year beginning on or after October 1, 2022, the No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits physicians, providers, health care facilities, and air ambulance companies from balance billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for in-network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from an out-of-network provider or facility, when a Covered Person receives non-emergency services from an out-of-network provider at an in-network facility, and when a Covered Person receives out-of-network air ambulance services.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by an out-of-network provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without Preauthorization; cover Emergency Services by out-of-network providers; base cost sharing amounts on in-network benefits; and count any cost sharing amounts for Emergency Services or out-of-network services toward a Covered Person’s out-of-pocket limit.

If a Covered Person believes he or she has received a balance bill that is protected under the No Surprises Act, please the Claims Processor, Delta Health Systems, at (800) 422-6099, for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

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.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below and in any packet of information distributed by the Utilization Management Organization (U.M.O.). The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost-efficient sources. The U.M.O. which is assisting in cost management for the Plan is:

Blue Shield of California
P. O. Box 272540, Chico, CA 95927-2540
Phone: (800) 541-6652

PRE-SERVICE REVIEW REQUIREMENTS

For a full list of the procedures that require pre-service review, please contact the utilization management organization providing pre-service review at the number listed on the back of the identification card.

Inpatient Admission - Except as noted, at least seven (7) days prior to any Hospital, Skilled Nursing Facility or Rehabilitation Center admission that is not a Medical Emergency, the Covered Person or his attending Physician is required to contact the Utilization Management Organization for pre-service review and authorization and follow with the filing of any necessary forms.

In the case of an emergency hospitalization (admission for treatment of a condition which, if treated on an Outpatient basis, could lead to disability or death), patient, doctor, or a family member must phone the Utilization Management Organization within 24 hours of admission - or on the first business day following a weekend or holiday admission.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that 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, pre-service review for such extended confinement is required.

Surgery Review – A Covered Person or his attending Physician is required to call the Utilization Management Organization prior to the performance of any elective (non-emergency) surgery. The U.M.O. will review the proposed surgery and may recommend that a second surgical opinion be obtained or that the procedure be performed in an Outpatient setting.

Home Health Care – A Covered Person or his attending Physician must obtain pre-service review and authorization of home health care services (i.e., services of a Home Health Care Agency), even if such services immediately follow a Hospital confinement for the same or a related condition. See “Home Health Care” in the list of **Eligible Medical Expenses** for additional information.

Organ and Tissue Transplants – A Covered Person or his attending Physician must obtain pre-service review and authorization for any non-investigative organ and tissue transplant. The U.M.O. will review the proposed procedure to determine that it is Medically Necessary and appropriate and verify that the procedure will be performed at a prescribed transplant facility.

Home Infusion Therapy – A Covered Person or his attending Physician must obtain pre-service review and authorization for all Home Infusion Therapy services.

NOTE: 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 COURSE OF TREATMENT IS MEDICALLY NECESSARY AND APPROPRIATE AND THAT THE PROPOSED SETTING IS THE MOST APPROPRIATE AS DETERMINED BY THE U.M.O. BENEFITS UNDER THE PLAN WILL DEPEND UPON THE PERSON'S ELIGIBILITY FOR COVERAGE AND THE PLAN'S LIMITATIONS AND EXCLUSIONS.

DECISIONS REGARDING THE COURSE OF TREATMENT ARE SOLELY THE RESPONSIBILITY OF THE COVERED PERSON AND HIS PROVIDER. THE PURPOSE OF ESTABLISHING THE **UTILIZATION**

MANAGEMENT PROGRAM IS TO ASSIST THE COVERED PERSON IS IDENTIFYING THE MOST APPROPRIATE AND COST-EFFECTIVE COURSE OF TREATMENT.

CASE MANAGEMENT SERVICES

Catastrophic Case Management Services - On a case-by-case basis as selected by the Plan Sponsor, **WellPoint Life Insurance Company** will provide case management services for large or potentially large claims.

| |
|---|
| Blue Shield of California P. O. Box 272540, Chico, CA 95927-2540 Phone: (800) 541-6652 |
|---|

As part of case management, FHCA, Inc. will summarize the patient's medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

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.

Penalty for Failure to Comply - A 50% reduction of the Plan's normal liability will be imposed if a Covered Person refuses to participate in recommended case management.

• • • • •

SELF-AUDIT PROGRAM

To encourage examination and self-auditing of eligible medical bills, the Plan offers an incentive credit to Covered Persons to ensure that the amount billed by any provider of service accurately reflects the services and supplies received.

A Covered Person is voluntarily asked to review all Hospital and doctor bills and verify that he/she has received each itemized service and that the bill does not represent either an overcharge or a charge for services never received (regardless of the reason). The Plan Administrator agrees to assist the Covered Person (at his or her request) in determination of errors and recovery attempts.

If the event a Covered Person's self-audit results in elimination or reduction of charges, 25% of the amount so eliminated or reduced will be paid directly to the Employee - subject to a \$10 minimum savings, provided the savings are accurately documented and satisfactory evidence of a reduction in charges is submitted to the Contract Administrator (i.e., a copy of the incorrect bill and a copy of the corrected billing).

Participation in this self-auditing procedure is strictly voluntary.

NOTE: This incentive credit will not apply to charges in excess of the Usual and Customary and Reasonable charge, regardless of whether such charge is or is not reduced.

MEDICAL BENEFIT SUMMARY

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). In California, network providers are those participating in the **Blue Shield Shared Advantage Network**. Outside of California, network providers are those participating in the **Blue Shield Card Network**. For Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy services the Network providers are a part of the **PhysMetrics Network**. For mental health services the Network providers are part of the **Halcyon Behavioral Network**. Note: Sutter Health network, including physicians and hospitals, are Non-Network providers under this Plan.

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.

The Plan Sponsor will automatically provide a Plan participant with information about how he can access a directory of Network Providers. This information will be provided without charge. The directory will be available either in hard copy as a separate document, or in electronic format. Since certain covered services and supplies may not be available through the Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included.

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

Emergency Services - If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network provider care. At that point, the Covered Person must be transferred to Network-provider care or Non-Network benefit levels will commence. Notwithstanding the foregoing, The Network Provider level of benefits is payable when a Covered Person receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

Referral by a Network Provider - If a Covered Person's Network provider refers him to a Non-Network provider because the necessary specialty is not represented in the Network or is not reasonably accessible to the patient due to geographic constraints, such Non-Network care will be covered at the benefit level for Network care.

No Choice of Provider - If, while receiving covered treatment in a Network facility, a Covered Person receives ancillary services from a Non-Network provider in a situation in which he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels. The Network Provider level of benefits is payable if a Covered Person receives Physician or anesthesia services, or other non-emergency items or services as defined by the No Surprises Act, by a Non-Network Provider at a Network Hospital or Network facility.

Emergency Services as required by the No Surprises Act - The Network Provider level of benefits is payable if a Covered Person receives Emergency Services at a Non-Network facility, to the extent required by the No Surprises Act.

SPECIAL NOTICE ON REFERRALS – 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.

CLAIMS AUDIT

The Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to either a Network negotiated rate or Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. For Network providers, this means that the percentages apply to the negotiated rates. For Non-Network providers in the same service area as Network providers, percentages apply to amounts that would have been paid to a Network provider.

MEDICAL BENEFIT SUMMARY, continued

For Non-Network providers in a service area where no Network providers are available, percentages apply to “Usual and Customary” and “Reasonable”. See “Usual and Customary” and “Reasonable” in the **Definitions** section for more information.

“Co-Pay” is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

IMPORTANT: CERTAIN HEALTH CARE SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

MODERN CARE PLAN

| LIFETIME & ANNUAL MAXIMUMS | | UNLIMITED FOR ESSENTIAL HEALTH BENEFITS (“EHB”); \$1.5M FOR NON-EHB | |
|--|--|---|-------------|
| Lifetime dollar limits are <u>not allowed</u> for “essential health benefits.” Essential health benefits include the following: | | | |
| Ambulatory patient services | | | |
| Emergency services | | | |
| Hospitalization | | | |
| Maternity and newborn care | | | |
| Mental health and substance use disorders | | | |
| Prescription drugs | | | |
| Rehabilitative and habilitative services and devices | | | |
| Laboratory services | | | |
| Preventative and wellness services and chronic disease management | | | |
| Pediatric services | | | |
| NOTE: Total Plan benefits for non-essential health benefits for each Covered Person will not exceed the \$1,500,000 Maximum Benefit. Lower limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are also included in this summary. | | | |
| If less than the full Maximum Plan Benefit applicable to the Covered Person is available at the beginning of a Calendar Year, the used portion of the Maximum Plan Benefit will be restored to the extent of the lesser of: (1) the amount needed to restore the full Maximum Plan Benefit applicable to the Covered Person, or (2) \$1,000. Restoration is available only on the Maximum Plan Benefit and is not available to any lesser maximums as may apply to specific conditions or types or levels of care. | | | |
| CALENDAR YEAR DEDUCTIBLES | | Network | Non-Network |
| Individual Deductible | | \$400 | \$5,000 |
| Family Maximum Deductibles | | \$1,200** See Below | **See below |
| <u>Individual Deductible</u> - The Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses. The deductible usually applies before the Plan begins to provide benefits. | | | |
| <u>Family Maximum Deductibles</u> - An individual within a family shall not have a deductible that is more than the individual deductible limit. **To satisfy the family deductible, three family members must each meet their individual deductible. Network Provider deductible is not applied toward the Non-Network Provider deductible. A "family" includes a covered Employee and his covered Dependents. | | | |
| Network and Non-Network Deductibles do not cross-apply. Expenses applied toward the Network Deductible will not also apply to the Non-Network Deductible or vice versa. | | | |
| <u>Common Accident Provision</u> - If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. | | | |
| † Calendar Year Deductible does not apply. | | | |

MEDICAL BENEFIT SUMMARY, continued

| OUT OF POCKET MAXIMUMS | Network | Non-Network |
|---|---|---|
| Individual Maximum | \$3,000 | \$10,000 |
| Family Maximum | \$9,000 | \$30,000 |
| <p>Except as noted, a Covered Person will not be required to pay more than \$10,000 (or \$2,000 for Network services and supplies) in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p><u>Family Out of Pocket Maximum</u> - For family coverage, an individual within a family shall not have a maximum out of pocket limit that is greater than the maximum out of pocket limit for an individual. After the individual maximum has been satisfied by a person enrolled in family coverage, the plan will play the remaining charges incurred by that person. The out of pocket amount includes copays, deductible and coinsurance amounts for 'essential health benefits' as defined under the Affordable Care Act.</p> <p>For the 2019 plan year and thereafter, the combined Medical and Prescription annual Out of Pocket maximum for covered services received In-Network will not exceed limits of \$7,900 per Individual or \$15,800 for Family coverage.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> amounts applied or paid to satisfy any Deductible or Co-Pay requirements for Network non-essential health benefits, all Non-Network spending, and all spending for non-covered services or items; Expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program (see "Case Management Services"). | | |
| PRESCRIPTION OUT-OF-POCKET MAXIMUMS | \$3,000 Individual - \$7,500 Family (Network Providers Only; Only co-pays count toward Out-of-Pocket Maximum) | |
| ELIGIBLE MEDICAL EXPENSES | Network | Non-Network |
| Ambulance | 90% | 90% Non-emergency use -50% |
| Ambulatory Surgical Center , per admission | \$150 Co-Pay, then 90% | \$150 Co-Pay, then 50% (\$750 Co-Pay applies to Summit Surgical) |
| Chiropractic Care | (see "Spinal Manipulation, Chiropractic" below) | |
| Diagnostic Services (lab and x-ray, outpatient) | | |
| Regular Services, per visit | \$30 Co-Pay, then 90% | \$30 Co-Pay, then 50% |
| Complex Services (generally those over \$500), per visit | \$75 Co-Pay, then 90% | \$75 Co-Pay, then 50% |
| ELIGIBLE MEDICAL EXPENSES | Network | Non-Network |
| Durable Medical Equipment | 90% | 50% |
| Home Health Care | 90% | 50% |
| Limited to 2 visits per day. Each visit by a nurse, a therapist or social service worker, and each visit of up to 4 hours of home health aide services will count as 1 visit. | | |
| Hospice Care | 90% | 50% |

MEDICAL BENEFIT SUMMARY, continued

| | | |
|--|------------------------|------------------------|
| Hospital Services | | |
| Inpatient Care, per day – see NOTES | \$250 Co-Pay, then 90% | \$250 Co-Pay, then 50% |
| Emergency Room, per use – see NOTES: | | |
| in a true emergency | \$300 Co-Pay, then 90% | \$300 Co-Pay, then 90% |
| in a non-emergency situation | \$300 Co-Pay, then 90% | \$300 Co-Pay, then 50% |
| Outpatient Surgery Department, per use | \$200 Co-Pay, then 90% | \$200 Co-Pay, then 50% |
| † Calendar Year Deductible does not apply. | | |

NOTES: Total Inpatient “per day” Co-Pays will not exceed \$750 per admission.

The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.

Emergency Services include a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished. These services include those provided at an independent freestanding emergency department as well as a Hospital emergency department. A decision of what constitutes emergency services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

| | | |
|--|------------------------|------------------------|
| Mental Health & Substance Use Disorder Care | | |
| Inpatient Hospital Care, per day – see NOTES | \$250 Co-Pay, then 90% | \$250 Co-Pay, then 50% |
| Emergency Room, per use – see NOTES: | | |
| in a true emergency | \$250 Co-Pay, then 90% | \$250 Co-Pay, then 90% |
| in a non-emergency situation | \$250 Co-Pay, then 90% | \$250 Co-Pay, then 50% |
| Physician Inpatient Care & Consultations | 90% | 50% |
| Physician Office or Home Visits, per visit | \$30 Co-Pay† | 50% |

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 Care / 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). Network is Halcyon Behavioral.

NOTES: Total Inpatient “per day” Co-Pays will not exceed \$750 per admission.

The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.

| | | |
|--|--------------|-----|
| Physician Services | | |
| Inpatient Visits | 90% | 50% |
| Consultations | 90% | 50% |
| Office or Home Visits, per visit | \$30 Co-Pay† | 50% |
| Specialist Office Visits, per visit (not chiropractic or mental health care) | \$60 Co-Pay† | 50% |
| Injections (not immunizations) | 90% | 50% |
| Other Services (surgeon, assist. surgeon, anes., etc.) | 90% | 50% |

MEDICAL BENEFIT SUMMARY, continued

| MEDICAL BENEFIT SUMMARY, continued | |
|---|---|
| ELIGIBLE MEDICAL EXPENSES | Network Non-Network |
| Prescription Drugs, Outpatient <u>Retail Feature</u> (34-day supply, formulary) Oral Contraceptives Other Generic Drug Brand-Name Drug (no generic available) Brand-Name Drug (generic available)** | \$0 Co-Pay† \$10 Co-Pay† \$45 Co-Pay† \$80 Co-Pay† |
| <u>Mail-Order Option</u> Oral Contraceptives (90-day supply, formulary) Other Generic Drug | \$0 Co-Pay† 2 Co-Pays, per drug purchase |
| † Calendar Year Deductible does not apply. | |
| <p>Prescription drug coverage involves a program through an independent vendor. To use the retail program, 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 34-day supply for the Co-Pays shown.</p> <p>**The prescription drug program includes a mandatory generic program; if a member or physician chooses to receive a brand medication with a generic equivalent, the member will pay a Dispense as Written (“DAW”) Penalty, plus the generic copay. The cost difference between generic and brand medication, when generic is available and medically-appropriate, will not count toward the Out of Pocket Maximum; only the co-pay will count toward the Out of Pocket Maximum. The DAW Penalty will be avoided for members who meet the Medical Necessity Requirement for brand medication. Use of a brand medication with a generic equivalent may be approved through the clinical review process if a prescriber deems that a brand medication is medically necessary compared to its generic equivalent, as follows: (1) Trial and failure of two generic medications by different manufacturers documented in the member’s prescription history or office notes within the past 12 months; AND (2) Completion of FDA MedWatch Form 3500 and filing it with the FDA to document adverse effects to the generic modifications for each generic medication. (Confirmation of FDA acknowledgment and receipt of MedWatch Form 3500 Filing.)</p> <p>The program also includes a mandatory mail-order option for maintenance drugs (i.e., drugs for long-term use such as for treatment of diabetes, heart disease, allergies, etc.). Mail-order drugs are available in up to a 90-day supply for 2 retail Co-Pays. The mail-order program may be used after 2 refills of a maintenance drug at a retail pharmacy.</p> <p>A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor. Contact IPM at (877) 860-8846 for the current list of prescription drug exclusions and limitations.</p> <p>Coverage is limited for drugs purchased outside of the drug card program. A Covered Person must submit a copy of the paid drug receipt, along with a photocopy of his prescription ID card, to the drug card vendor. A Covered Person will be reimbursed the contract price of the drug, less the Co-Pay requirement and other appropriate charges. Step therapy and Pre-authorization requirements may apply for certain drug categories.</p> <p>The prescription drug program includes a variable co-pay assist program, and medical management techniques for certain drug categories, including but not limited to Step therapy and Pre-authorization requirements. The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). IPM Basic Formulary, IPM Standard Exclusion List, and Preferred Drug List applies.</p> <p>NOTES: IPM will offer a network of specialty pharmacy services in order to provide services to individuals with complex chronic conditions. Specialty drugs will be subject to a \$250 Co-Pay for a one-month supply.</p> <p>Drugs not available through the prescription drug program but that are eligible under the Plan will be covered as medical benefits. A specialty pharmacy must be used unless it cannot be used due to Medical Necessity.</p> | |

MEDICAL BENEFIT SUMMARY, continued

| | | |
|--|---|---|
| Preventive Care <u>Federally-Required Preventive Care Benefits</u> <u>Other Preventive Care:</u> (if not included in Federally-Required) Annual Physical Exam Well Child Care | 100%† 100% 100% | Not Covered Not Covered Not Covered |
| <u>Federally-Required Preventive Care Benefits:</u> To the extent the services described in the Appendix for Federally-Required Benefits exceed the “Other Preventive Care Services” (see below), preventive care is covered in full (i.e., no cost sharing) when Network providers are used. Preventive Care Benefits are mandated by the ACA. | | |
| <u>Other Preventive Care Services</u> (to the extent they are not included in the Federally-Required Benefits): 1 routine physical exam in each Calendar Year for a covered Employee or covered Dependent spouse. The Physical exam must be performed by a Network provider and includes routine mammograms and a Pap smear, if indicated; Well child care for a covered Dependent child up to 1 year of age, including periodic routine Physician exams and related diagnostic services as well as immunizations. | | |
| Radiation Therapy | 90% | 50% |
| Skilled Nursing Facility / Rehabilitation Center | 90% | 50% |
| Eligible Expenses for room and board are limited to the facility’s Semi-Private Room Charge. | | |
| Smoking Cessation † Calendar Year Deductible does not apply. | 90% | 50% |
| Limited to \$450 in benefits per Lifetime. Federally-required tobacco use screening and two tobacco cessation attempts per year are a preventative service not subject to an annual or lifetime maximum. | | |
| Spinal Manipulation, Chiropractic Chiropractic Office Visit, per visit Chiropractic Spinal Manipulation | \$30 Co-Pay† 90% | 100% maximum plan payment to \$15 per visit |
| Limited to \$500 in benefits per Calendar Year. Network is PhysMetrics. | | |
| Substance Abuse Care | (see “Mental Health & Substance Use Disorder Care”) | |
| Telehealth/Internet-Based Services | | |
| Effective March 2020 and thereafter, telehealth visits shall be authorized as benefits provided at the in-person physician office visit rate. Telehealth is also available as a covered service when rendered by a Teladoc provider. | | |
| TMJ / Jaw Joint Treatment | (benefits are based on types of services provided) | |
| Limited to \$7,500 in benefits per Lifetime. | | |
| Urgent Care Facility , per visit | \$50 Co-Pay, then 90% | \$50 Co-Pay, then 90% |
| All Other Eligible Medical Expenses † Calendar Year Deductible does not apply. | 90% | 50% |

BRONZE PLAN

| LIFETIME & ANNUAL MAXIMUMS | UNLIMITED FOR ESSENTIAL HEALTH BENEFITS (“EHB”); \$1.5M FOR NON-EHB | |
|--|---|-------------|
| Lifetime dollar limits are <u>not allowed</u> for “essential health benefits.” Essential health benefits include the following: <div><div>Ambulatory patient services</div><div>Emergency services</div><div>Hospitalization</div><div>Maternity and newborn care</div><div>Mental health and substance use disorders</div><div>Prescription drugs</div><div>Rehabilitative and habilitative services and devices</div><div>Laboratory services</div><div>Preventative and wellness services and chronic disease management</div><div>Pediatric services</div></div> | | |
| NOTE: Total Plan benefits for non-essential health benefits for each Covered Person will not exceed the \$1,500,000 Maximum Benefit. Lower limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are also included in this summary. If less than the full Maximum Plan Benefit applicable to the Covered Person is available at the beginning of a Calendar Year, the used portion of the Maximum Plan Benefit will be restored to the extent of the lesser of: (1) the amount needed to restore the full Maximum Plan Benefit applicable to the Covered Person, or (2) \$1,000. Restoration is available only on the Maximum Plan Benefit and is not available to any lesser maximums as may apply to specific conditions or types or levels of care. | | |
| CALENDAR YEAR DEDUCTIBLES | Network | Non-Network |
| Individual Deductible | \$5,000 | No Coverage |
| Family Maximum Deductibles | **See Below | |
| <u>Individual Deductible</u> - The Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses. The deductible usually applies before the Plan begins to provide benefits. <u>Family Maximum Deductibles</u> - An individual within a family shall not have a deductible that is more than the individual deductible limit. **To satisfy the family deductible, two family members must each meet their individual deductible. Network Provider deductible is not applied toward the Non-Network Provider deductible. A "family" includes a covered Employee and his covered Dependents. <u>Common Accident Provision</u> - If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. | | |

† Calendar Year Deductible does not apply

MEDICAL BENEFIT SUMMARY, continued

| OUT OF POCKET MAXIMUMS | Network | Non-Network |
|--|--|--|
| Individual Maximum | \$6,850 | No Coverage |
| Family Maximum | \$13,700 | |
| <p>Except as noted, a Covered Person will not be required to pay more than \$6,600 (or \$13,200 per family for Network services and supplies) in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Out of Pocket Maximums include prescription services. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p><u>Family Out of Pocket Maximum</u> - For family coverage, an individual within a family shall not have a maximum out of pocket limit that is greater than the maximum out of pocket limit for an individual. After the individual maximum has been satisfied by a person enrolled in family coverage, the plan will play the remaining charges incurred by that person. The out of pocket amount includes copays, deductible and coinsurance amounts for 'essential health benefits' as defined under the Affordable Care Act.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> amounts applied or paid to satisfy any Deductible or Co-Pay requirements for Network non-essential health benefits, all Non-Network spending, and all spending for non-covered services or items; Expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program (see "Case Management Services"). | | |
| PRESCRIPTION OUT-OF-POCKET MAXIMUMS | Included in Medical Out Of Pocket Maximums (Network Providers Only; Only co-pays count toward Out-of-Pocket Maximum) | |
| ELIGIBLE MEDICAL EXPENSES | Network | Non-Network |
| Ambulance | 70% | 70% Non-emergency use – NOT COVERED |
| Ambulatory Surgical Center , per admission | 70% | No Coverage |
| Chiropractic Care | (see "Spinal Manipulation, Chiropractic" below) | |
| Diagnostic Services (lab and x-ray, outpatient) | | |
| Regular Services, per visit | 70% | No Coverage |
| Complex Services (generally those over \$500), per visit | 70% | Not Covered |
| Durable Medical Equipment | 70% | Not Covered |
| Home Health Care | 70% | Not Covered |
| Limited to 2 visits per day. Each visit by a nurse, a therapist or social service worker, and each visit of up to 4 hours of home health aide services will count as 1 visit. | | |
| Hospice Care | 70% | Not Covered |
| Hospital Services | | |
| Inpatient Care, per day – see NOTES | 70% | Not Covered |
| Emergency Room, per use – see NOTES: | | |
| in a true emergency | \$300 Co-Pay, then 70% | \$300 Co-Pay, then 70% |
| in a non-emergency situation | Not Covered | Not Covered |
| Outpatient Surgery Department, per use | 70% | Not Covered |
| <p>Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital or Non-Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital in a service area where no Network Hospitals are available, to the Semi-Private Room Charge (see Definitions) or the Usual and Customary and Reasonable charge for an Intensive Care Unit. Excess charges for a private room accommodation will be covered when Medically Necessary.</p> <p>† Calendar Year Deductible does not apply.</p> | | |

MEDICAL BENEFIT SUMMARY, continued

NOTES: Total Inpatient “per day” Co-Pays will not exceed \$750 per admission.

The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.

Emergency Services include a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished. These services include those provided at an independent freestanding emergency department as well as a Hospital emergency department. A decision of what constitutes emergency services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

| | | |
|--|------------------------|------------------------|
| Mental Health & Substance Use Disorder Care | | |
| Inpatient Hospital Care, per day – see NOTES | 70% | Not Covered |
| Emergency Room, per use – see NOTES: | | |
| in a true emergency | \$150 Co-Pay, then 70% | \$150 Co-Pay, then 70% |
| in a non-emergency situation | 70% | Not Covered |
| Physician Inpatient Care & Consultations | 70% | Not Covered |
| Physician Office or Home Visits, per visit | \$60 Co-Pay† | Not Covered |

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 Care / 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). Network is Halcyon Behavioral.

NOTES: Total Inpatient “per day” Co-Pays will not exceed \$750 per admission.

The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.

| | | |
|--|--------------|-------------|
| Physician Services | | |
| Inpatient Visits | 70% | Not Covered |
| Consultations | 70% | Not Covered |
| Office or Home Visits, per visit | \$60 Co-Pay† | Not Covered |
| Injections (not immunizations) | 70% | Not Covered |
| Other Services (surgeon, assist. surgeon, anes., etc.) | 70% | Not Covered |

| | |
|--|------------------------------|
| Prescription Drugs, Outpatient | |
| <u>Retail Feature</u> (34-day supply, formulary) | |
| Oral Contraceptives | \$0 Co-Pay† |
| Other Generic Drug | \$10 Co-Pay† |
| Brand-Name Drug (no generic available) | \$45 Co-Pay† |
| Brand-Name Drug (generic available)** | \$80 Co-Pay† |
| <u>Mail-Order Option</u> | |
| Oral Contraceptives (90-day supply, formulary) | \$0 Co-Pay† |
| Other Generic Drug | 2 Co-Pays, per drug purchase |

MEDICAL BENEFIT SUMMARY, continued

Prescription drug coverage involves a program through an independent vendor. To use the retail program, 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 34-day supply for the Co-Pays shown.

† Calendar Year Deductible does not apply.

****The prescription drug program includes a mandatory generic program; if a member or physician chooses to receive a brand medication with a generic equivalent, the member will pay a Dispense as Written (“DAW”) Penalty, plus the generic copay. The cost difference between generic and brand medication, when generic is available and medically-appropriate, will not count toward the Out of Pocket Maximum; only the co-pay will count toward the Out of Pocket Maximum. The DAW Penalty will be avoided for members who meet the Medical Necessity Requirement for brand medication. Use of a brand medication with a generic equivalent may be approved through the clinical review process if a prescriber deems that a brand medication is medically necessary compared to its generic equivalent, as follows: (1) Trial and failure of two generic medications by different manufacturers documented in the member’s prescription history or office notes within the past 12 months; AND (2) Completion of FDA MedWatch Form 3500 and filing it with the FDA to document adverse effects to the generic modifications for each generic medication. (Confirmation of FDA acknowledgment and receipt of MedWatch Form 3500 Filing.)**

The program also includes a mandatory mail-order option for maintenance drugs (i.e., drugs for long-term use such as for treatment of diabetes, heart disease, allergies, etc.). Mail-order drugs are available in up to a 90-day supply for 2 retail Co-Pays. The mail-order program may be used after 2 refills of a maintenance drug at a retail pharmacy.

A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor. Contact IPM at (877) 860-8846 for the current list of prescription drug exclusions and limitations.

Coverage is limited for drugs purchased outside of the drug card program. A Covered Person must submit a copy of the paid drug receipt, along with a photocopy of his prescription ID card, to the drug card vendor. A Covered Person will be reimbursed the contract price of the drug, less the Co-Pay requirement and other appropriate charges. Step therapy and Pre-authorization requirements may apply for certain drug categories.

The prescription drug program includes a variable co-pay assist program, and medical management techniques for certain drug categories, including but not limited to Step therapy and Pre-authorization requirements. The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). IPM Basic Formulary, IPM Standard Exclusion List, and Preferred Drug List applies.

NOTES: IPM will offer a network of specialty pharmacy services in order to provide services to individuals with complex chronic conditions. Specialty drugs will be subject to a \$250 Co-Pay for a one-month supply.

Drugs not available through the prescription drug program but that are eligible under the Plan will be covered as medical benefits. A specialty pharmacy must be used unless it cannot be used due to Medical Necessity

Preventive Care

Federally-Required Preventive Care Benefits

100%†

Not Covered

Other Preventive Care: (if not included in Federally-Required)

Annual Physical Exam

100%

Not Covered

Well Child Care

100%

Not Covered

Federally-Required Preventive Care Benefits: To the extent the services described in the **Appendix for Federally-Required Benefits** exceed the “Other Preventive Care Services” (see below), preventive care is covered in full (i.e., no cost sharing) when Network providers are used. Preventive Care Benefits are mandated by the ACA.

Other Preventive Care Services (to the extent they are not included in the Federally-Required Benefits):

1 routine physical exam in each Calendar Year for a covered Employee or covered Dependent spouse. The Physical exam must be performed by a Network provider and includes routine mammograms and a Pap smear, if indicated;

Well child care for a covered Dependent child up to 1 year of age, including periodic routine Physician exams and related diagnostic services as well as immunizations.

Radiation Therapy

70%

Not Covered

MEDICAL BENEFIT SUMMARY, continued

| | | |
|--|---|----------------------------|
| Skilled Nursing Facility / Rehabilitation Center | 70% | Not Covered |
| Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge. † Calendar Year Deductible does not apply. | | |
| Smoking Cessation | 70% | Not Covered |
| Limited to \$450 in benefits per Lifetime. Federally-required tobacco use screening and two tobacco cessation attempts per year are a preventative service not subject to an annual or lifetime maximum. | | |
| Spinal Manipulation, Chiropractic Chiropractic Office Visit, per visit Chiropractic Spinal Manipulation | \$60 Co-Pay† 70% | Not Covered Not Covered |
| Limited to \$500 in benefits per Calendar Year. Network is PhysMetrics. | | |
| Substance Abuse Care | (see "Mental Health & Substance Use Disorder Care") | |
| Telehealth/Internet-Based Services | | |
| Effective March 2020 and thereafter, telehealth visits shall be authorized as benefits provided at the in-person physician office visit rate. Telehealth is also available as a covered service when rendered by a Teladoc provider. | | |
| TMJ / Jaw Joint Treatment | (benefits are based on types of services provided) | Not Covered |
| Limited to \$7,500 in benefits per Lifetime. | | |
| Urgent Care Facility, per visit | 70% | Not Covered |
| All Other Eligible Medical Expenses | 70% | Not Covered |

† Calendar Year Deductible does not apply.

| <u>APPENDIX FOR FEDERALLY REQUIRED PREVENTIVE CARE BENEFITS</u> <u>(NO COST-SHARING)</u> |
|--|
| <p>The Affordable Care Act has designated the three agencies identified below to continuously review and update preventive care benefits to be offered under this Plan. These preventive care benefits are offered at no share of cost to the Plan participant when services are obtained from a Network provider. Services may also be obtained from Non-Network providers, although the benefit will be subject to the share of cost specified in the Medical Benefit Summary, Schedule of Medical Benefits.</p> <ul style="list-style-type: none"> • United States Preventive Services Task Force (A & B recommendations): https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ • Advisory Committee on Immunization Practices (adults, adolescents and children): https://www.cdc.gov/vaccines/schedules/parents-adults/index.html • Health Resources and Services Administration (women's preventive services) https://www.womenspreventivehealth.org/wellwomanchart/ |

| <u>APPENDIX FOR FEDERALLY-REQUIRED PREVENTIVE CARE BENEFITS: FOR WOMEN</u> <u>(AGE 18 & OLDER / NO COST-SHARING)</u> |
|--|
| Annual well-women visits (including preconception and prenatal care) |
| Screening for gestational diabetes |
| HPV testing for women over age 30 |
| Annual HIV screening and counseling |
| Breast cancer screening for women over age 40 |
| Breastfeeding support and counseling |
| Annual screening and counseling for domestic violence |
| All FDA-approved contraceptive methods (see Note under Eligible Medical Expenses: Prescription Drugs) |
| Sterilization procedures |
| Reproductive counseling, as prescribed |
| All preventive care benefits recommended in the Health Resources and Services Administration supported Women's Preventive Services Guidelines as updated from time-to-time |

| <u>APPENDIX FOR FEDERALLY-REQUIRED PREVENTIVE CARE BENEFITS:</u> <u>ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN</u> <u>(AGE 18 & OLDER / NO COST-SHARING)</u> | |
|---|---|
| Contraceptive Methods | Food and Drug Administration, approved: counseling, patient education, contraceptive methods (see Note under Eligible Medical Expenses: Prescription Drugs), and sterilization procedures as prescribed, for women with reproductive capacity |
| Interpersonal and Domestic Violence | Annual Screening and Counseling |
| 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 |
| Folic Acid | Supplements for woman who may become pregnant |

MEDICAL BENEFIT SUMMARY, continued

| | |
|-------------------|---|
| Gonorrhea | Screening for all women at higher risk |
| Osteoporosis | Screening for women over age 60, depending on risk factors |
| Well-woman visits | An annual adult well-woman visit to obtain the recommended preventive services that are age and developmentally appropriate, including pre-conception and prenatal care |

**APPENDIX FOR PREVENTIVE SERVICES FOR PREGNANCIES OF A
COVERED EMPLOYEE OR DEPENDENT SPOUSE
(NO COST-SHARING)**

| | |
|--|---|
| 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 for diabetes |
| Human Immune-Deficiency Virus | Annual screening and counseling |
| Human Papillomavirus | Screening beginning at 30 years of age, occurring no more frequently than every 3 years |
| Preeclampsia Preventive Medicine and Screening | Screening for preeclampsia with blood pressure measurements; Use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. |
| Sexually-Transmitted Infections | Annual counseling on sexually-transmitted infections for all sexually active women |
| Additional preventive care Screenings, Counseling, and Interventions as recommended by the Health Resources and Services Administration (HRSA) | Such additional evidence-informed preventive care, screenings, counseling and interventions as provided for in comprehensive guidelines supported by the HRSA |

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 (e.g. application of Deductible requirements and benefit sharing percentages). 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 subject to the Network negotiated rate or the Usual and Customary and Reasonable charges 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.

Abortion - A legal elective abortion or non-elective abortion procedure and any complications arising out of an abortion, but ONLY for an Employee or covered Dependent spouse.

Alcoholism - see "Substance Abuse Care" (page 23)

Ambulance - Professional local ambulance service when used to transport the Covered Person from the place where he is injured or stricken by a Sickness to the nearest Hospital for an Inpatient admission. Licensed air ambulance service will be covered when Medically Necessary to transport a Covered Person to the nearest facility equipped to provide the necessary care.

Ambulatory Surgical Center / Licensed Surgical Facility - 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 derivatives (if not replaced by or for the patient), including blood processing and administration services.

Chemical Dependency - see "Substance Abuse Care" (page 23)

Chemotherapy - Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

NOTE: High-dose chemotherapy (that requires collection and reinfusion of a patient's own blood and products as a supportive measure) is covered ONLY in connection with certain bone marrow transplant procedures - see "Transplants."

Chiropractic Care - see "Spinal Manipulations and Related Services" (page 23)

Circumcision - Circumcision of a newborn child.

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

Diagnostic Lab & X-ray, Outpatient - 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 Services and Supplies - Removal of blood from an artery (as of a kidney patient), purifying it by dialysis, adding vital substances, and returning it to a vein. Coverage also includes Outpatient maintenance home dialysis, dialysis supplies and home dialysis training.

Drug Abuse - see "Substance Abuse Care" (page 16)

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is the most cost-effective alternative. Any such equipment must be Medically Necessary, prescribed by a Physician and required for temporary therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, dialysis equipment (rental ONLY), 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.

Home Health Care - Services and supplies as listed herein which are furnished by a Home Health Care Agency to a Covered Person who is under the care of a Physician and which are furnished in accordance with a home health care plan which is established and periodically reviewed by the attending Physician.

All home health care services must be preauthorized by WellPoint Life Insurance Company (see **Utilization Management Program**), even if home health care follows a covered Hospital confinement for the same Sickness or Accidental Injury. The attending Physician must certify that proper treatment would require confinement as a resident Inpatient in the absence of the services and supplies provided as part of the home health care plan.

Covered Home Health Care Agency expenses will include visits by any of the following professionals:

- a registered graduate nurse (RN);
- a physical, occupational or speech therapist;
- a home health aide, provided the patient is also receiving RN or therapy services and when such services are ordered and supervised by an RN as the professional coordinator employed by the Home Health Care Agency;
- a qualified medical social service worker.

Covered Home Health Care Agency expenses will also include medical supplies, drugs and medicines prescribed by a Physician, laboratory services, but only to the extent that such charges would have been covered if the patient had been confined in the Hospital.

NOTE: Covered home health care services will not include dietitian services, homemaker services, maintenance therapy, hemodialysis services, purchase or rental of dialysis equipment, food or home-delivered meals, when such services or supplies are furnished by a Home Health Care Agency.

Hospice Care - Hospice care for a Covered Person with a terminal prognosis (life expectancy of six months or less). Eligible Expenses include charges for:

- nursing care;
- dietary and Hospice counseling services;

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

ELIGIBLE MEDICAL EXPENSES, continued

short-term Inpatient care for pain control and symptom management in a Hospice or Skilled Nursing Facility;

medical equipment;

medical supplies and drugs and biologicals for pain and symptom control; and

home health aide services.

NOTE: A "Hospice" is 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 which 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 Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

Immunizations - see "Preventive Care" in the **Medical Benefit Summary**

Infertility - Fertility studies, sterility studies, or procedures, drugs or supplies to restore or enhance fertility, including charges for any related treatment, but not including any type of artificial impregnation procedure.

Mammograms - see "Preventive Care" in the **Medical Benefit Summary**

Medical Supplies - Medical supplies such as casts, splints, trusses, head halters, traction apparatus, cervical collars, surgical dressings, colostomy bags and related supplies, catheters and cardiac pacemakers.

Medicines - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, as part of a home health care or hospice care program. See "Prescription Drugs, Outpatient" in the **Medical Benefit Summary** for pharmacy drugs (page 8).

Mental Health & Substance Use Disorder Care - Inpatient and Outpatient treatment of mental health conditions and substance use disorders. Confinement in a state-approved alcoholism rehabilitation, drug addiction or drug rehabilitation program will be covered in the same manner as treatment furnished by a Hospital.

Mental Health Conditions: For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence.

A mental health condition or covered mental health care will not include:

learning and behavior disorders including attention deficit disorder, hyperkinetic syndrome, or mental retardation;

marriage and family counseling;

sex counseling or sex therapy;

vocational testing or training.

Substance Use Disorders: For Plan purposes, a "substance use disorder" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree.

A "substance use disorder" does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

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

Midwife - Services of a registered nurse midwife.

Newborn Care - Medically Necessary services and supplies as listed herein for a covered newborn who is sick or injured.

See "Pregnancy Care" for well newborn coverage.

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

See also "Home Health Care" above.

Occupational Therapy - Occupational therapy (i.e. therapy by means of activity), when provided by a certified occupational therapist on referral from or under the direction of an MD or DO. Such therapy uses arts, crafts or specific training in daily living skills, to improve and maintain a patient's ability to function.

"Occupational therapy" is not to be confused with treatment for an occupational or work-related injury.

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 – see "Foot Care" in the list of **Medical Limitations and Exclusions**.

Oxygen - Oxygen and services and/or supplies for the administration of oxygen.

Pap Smear - see "Preventive Care" in the **Medical Benefit Summary Physical**

Exams - see "Preventive Care" in the **Medical Benefit Summary**

Physical Therapy - Professional services of 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.

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;

routine Hospital services and supplies provided for care of a healthy newborn for as long as the mother is necessarily confined following delivery.

In no instance will the Plan restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a 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 attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

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

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 (i.e., a Covered Person who carries a pregnancy with an agreement to surrender the newborn to the party who made the agreement for the pregnancy with the Covered Person), or (4) pregnancy-related expenses of a Dependent daughter other than Federally-required preventative services of preconception and pre-natal care where an attending provider determines that well-woman preventive services are age and developmentally appropriate for the Dependent daughter.

Prescription Drugs (Outpatient) - The charges for the following:

drugs and medicines which are lawfully obtainable **ONLY** upon the written prescription of a Physician (see NOTE); and

injectable testosterone, including syringes and/or needles for testosterone administration; and injectable insulin and clintest, including syringes and/or needles for insulin administration.

The Co-Pay requirement (see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**) is applied to each prescription purchase (i.e., the request for each separate drug or medication issued by a Physician, and each authorized refill of such request).

NOTES: Refills for drugs which are lost or stolen are not covered. Copay is waived for generic contraceptive products; copay is waived for brand contraceptive medications when there isn't a generic or therapeutic equivalent and the use is for contraception. Injectable, tretinoin preparations (such as Retin-A) and single-source brand birth control pills and devices are covered **ONLY** if Medically Necessary. The Medical Necessity must be authorized by the Contract Administrator in order for benefits to be payable under the Plan.

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 and eyes. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.

Radiation Therapy - Radium and radioactive isotope therapy.

NOTE: No coverage will be provided for high dose radiotherapy in connection with autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures, for any symptom, disease or condition, except as expressly shown in this section under "Transplant-Related Expenses."

Rehabilitation Center - see "Skilled Nursing Facility or Rehabilitation Center" (page 15)

Respiratory Therapy - Professional services of a licensed respiratory or inhalation 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.

Routine Patient Costs for Participation in an Approved Clinical Trial - Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition, provided:

1. The clinical trial is approved or funded by:
 - a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
 - b. The National Institute of Health;
 - c. The Agency for Health Care Quality and Research;
 - d. The Centers for Medicare & Medicaid Services;
 - e. The U.S. Food and Drug Administration;
 - f. The U.S. Department of Defense;
 - g. The U.S. Department of Veterans Affairs;

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

ELIGIBLE MEDICAL EXPENSES, continued

- h. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - i. An Institutional review board of an Institution in California that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
 2. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
4. A cost associated with managing an Approved Clinical Trial;
5. The cost of a health care service that is specifically excluded by the Plan; or
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

Second Surgical Opinion - A second surgical opinion consultation rendered within one (1) month of the 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 be independent of the Physician who initially recommended the surgery.

A third opinion consultation will also be covered if the second opinion obtained 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.

Skilled Nursing Facility or Rehabilitation Center - Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and admission has received prior approval – see **Utilization Management Program**.

Smoking Cessation - Nicotine patch and Physician services to assist a Covered Person to quit smoking.

Speech Therapy - Services by a qualified speech therapist, but only when used to restore or rehabilitate a speech loss or impairment caused by Accidental Injury or Sickness, including a mental, emotional or nervous disorder. In the case of a congenital defect that can be corrected or improved with surgery, speech therapy is covered only if provided after surgery for the defect.

Spinal Manipulations and Related Services - Manipulation by a Covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

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 Abuse Care - Inpatient and Outpatient treatment of addiction resulting from substance abuse. Confinement in a state-approved alcoholism rehabilitation, drug addiction or drug rehabilitation program will be covered in the same manner as treatment furnished by a Hospital.

For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other

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

ELIGIBLE MEDICAL EXPENSES, continued

addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

TMJ / Jaw Joint Treatment - Treatment of jaw joint problems, including temporomandibular joint syndrome, cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint. See also “Dental Care” and “Orthognathic Procedures” in the list of **Medical Exclusions and Limitations**.

Transplant-Related Expenses (Human Tissue) - Eligible Expenses incurred by a Covered Person who is the recipient of a non-experimental human organ or tissue transplant, subject to the following conditions:

services must be preauthorized by WellPoint Life Insurance Company (see **Utilization Management Program**);

the Plan must determine that the Covered Person satisfies their medical criteria for receiving transplant services;

the Plan must provide written referral for care to transplant facilities from a list of facilities the Plan has approved.

Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow transplantation (ABMT), stem cell rescue, or other hematopoietic support procedures are NOT covered except for the following conditions, and then only if the Covered Person qualifies as a candidate for ABMT under the health and age standards generally accepted by the national medical professional community:

- acute leukemia in remission
- resistant non-Hodgkin's lymphoma
- Hodgkin's disease
- neuroblastoma
- Ewing's sarcoma
- multiple myeloma (after induction therapy)
- non-inflammatory stage II breast cancer with 10 or more positive nodes and negative bone marrow

If the Plan (or in the case of a referral, the medical staff of the referral facility), determines that the Covered Person does not satisfy its criteria for the transplant service involved, the Plan will only pay for Eligible Expense provided prior to such determination.

Neither the Plan nor the Contract Administrator will undertake to furnish a bone marrow donor or a donor organ, to assure the availability of a donor or of a donor organ, or assure the availability or capacity of referral facilities approved by the Plan and, except for Medically Necessary ambulance service, will not provide for transportation or living expenses for any person, including the patient.

NOTES: Benefits may be reduced if a Covered Person refuses to participate in recommended case management (see **Case Management Program** section).

Experimental or investigational organ transplants (which may include bone marrow transplants in certain instances) are not covered.

Transplantation or implantation of non-human, artificial or mechanical organs, or any part thereof, are not covered.

Expenses of an organ or tissue donor, whether or not the donor is a Covered Person, are not covered.

Urgent Care Facility - see **Definitions**

Well Child Care - see “Preventive Care” in the **Medical Benefit Summary**

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:

Acupuncture / Acupressure

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.

Childhood Disorders - see “Learning & Behavioral Disorders”

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:

surgery which is Medically Necessary to correct a functional and physical disorder which is a result of a surgical procedure or Accidental Injury;

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 lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

treatment necessary to correct a congenital abnormality in a covered Dependent child.

Custodial & Maintenance Care - Care or confinement primarily for the purpose of meeting personal needs (e.g., bathing or walking) 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.

Dental & Oral Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

the repair or alleviation of damage to natural teeth or the jaw caused solely by Accidental Injury and provided such treatment is rendered within six (6) months after the accident. Damage resulting from biting or chewing will not be considered to be Accidental Injury for these purposes;

up to three (3) days of Hospital room and board, when Inpatient confinement is necessary for a dental procedure which requires general anesthesia.

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.

Confinement which is designed to control or change a person's environment, such as confinement in an eating disorder unit.

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.

Excess Charges - Charges in excess of the Network negotiated rate, or Usual and Customary and Reasonable fees, for services or supplies.

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).

Gene Therapy and Cell Therapy – whether or not the treatment or therapy is approved by the FDA or is considered investigational or experimental.

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders.

Hair Restoration - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, including replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body.

Hearing Aids, Devices or Related Examinations - Hearing aids, devices or exams, unless required due to Accidental Injury and then limited to expenses that are incurred within six (6) months of the accident.

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

Hypnotherapy - Treatment by hypnotism, except as part of a Physician's treatment of a mental health condition or when hypnosis is used in lieu of an anesthetic.

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. Testing and treatment for ADHD is available for children up to age 18 only, with prescription drug benefits covered in accordance with the applicable medical-management program; additional information available from IPM prescription benefit manager for Plan.

Maintenance Care - see "Custodial & Maintenance Care"

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

Massage Therapy

Non-Prescription Drugs - Drugs 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 for insulin and supplies for its administration, and nicotine patches which are provided as part of the "Smoking Cessation" benefits. Drugs 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.

Obesity - see "Weight Control"

Orthognathic Procedures - Mandibular or maxillofacial surgery to correct growth defects, jaw disproportions or malocclusions, except for correction of a congenital anomaly in a child who was covered under the Plan from birth.

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

Penile Implants - Penile implants and services related to the implantation of a penile prosthesis, except when necessitated by direct physical trauma, tumor or irreversible vascular disease.

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.

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**.

Psychological Testing - Psychological testing provided on an Outpatient basis.

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 - Sexual problems, dysfunctions, or inadequacies which are not related to a medical problem, physical defect, or organic disease.

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

Vision supplies (e.g., eyeglasses or contact lenses) 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: This exclusion will not apply to expenses incurred within six (6) months of intraocular surgery or Accidental Injury to the eye.

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 - Services or supplies for obesity, weight reduction or dietary control, except when surgery is necessitated by a specifically identifiable medical condition of morbid obesity – see NOTE.

NOTE: A Fresno-based Plan-sponsored weight management program is available for a Plan participant who is a candidate for weight reduction surgery. For Plan participants who reside in Kings, Tulare, Fresno and Madera counties, that program is required and must first be completed and the surgery must be authorized in order for Plan benefits to be available.

Wigs or Wig Maintenance - Purchase of a wig for cosmetic or hair loss purposes, whether or not hair loss is the result of Sickness or medical treatment (such as chemotherapy); or the repair, replacement or maintenance (cleaning, etc.) of a wig.

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

GENERAL EXCLUSIONS

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

Court-Ordered Care, Confinement or Treatment - Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order.

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 being the victim of 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.

Excess Charges - Charges in excess of the Usual and Customary and Reasonable fees for services or supplies provided by non-network providers out of the state of California.

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, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

approval of the U.S. Food and Drug Administration for marketing the drug or device 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 information.

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.

HMO/EPO Services & Supplies – Any charge which would have been covered by an HMO/EPO on a “primary payor” basis if the patient had used the services of an HMO/EPO provider. Any charge in excess of what an HMO/EPO provider has agreed to accept as payment in full.

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.

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 that a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to services rendered by a Charitable Research Hospital, as defined herein, or to benefits or coverage available through the Medical Assistance Act (Medicaid) or when prohibited by law.

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

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 sole 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 Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

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.

Relative or Resident 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 or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from being the victim of domestic violence (e.g., depression).

Telecommunications - Advice or consultation given by or through any form of telecommunication, except as may be authorized by the U.M.O. (see **Utilization Management Program**, page 3).

Testosterone - Available only as an injectable, except when topical testosterone replacement therapy is used in the treatment of primary or hypogonadotropic hypogonadism (congenital or acquired).

Third Party Liabilities - Any expenses caused by any third party when payment for such expenses has been paid (or will be paid) by the third party or the third party's insurance company. See section entitled **Subrogation and Reimbursement Provisions** (page 29) for further information.

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**.

Veterans Hospital - see “Government-Operated Facilities” (page 29)

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 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, whether or not a claim is made for such benefits. 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 benefits provided under the Plan are subject to the following provisions and limitations, unless specifically stated otherwise.

DEFINITIONS

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

Other Plan - Other Plans will NOT include HMOs but will include benefits, services or treatment, provided by: group,

blanket or franchise coverage, whether insured or not;

group Blue Cross and Blue Shield coverages;

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

individual auto insurance which is subject to any state automobile insurance law. In a state where "no fault" or Personal Injury Protection is mandated, a Covered Person will be presumed to have at least the minimum coverage requirement of the state of jurisdiction, whether or not such coverage is actually in force;

any coverage under government programs, such as TRICARE, and any coverage required or provided by a statute (see NOTE). For purposes of implementing this provision, eligibility alone will constitute coverage.

NOTE: See "Special Provisions With Respect to Medicare" at the end of this section for Medicare-related handlings.

This Plan - The coverages of this Plan.

Allowable Expense - Any Usual and Customary and Reasonable item of expense incurred while the person for whom claim is made is covered under This Plan, at least a part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

NOTE: An Allowable Expense will NOT include any charge which would have been covered by an HMO on a "primary payor" basis if the patient had used the services of an HMO provider.

Claim Determination Period - A period which 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.

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, This Plan will pay the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid 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" guidelines below.

If, in accordance with those guidelines, 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 the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

NOTE: The determination of “normal liability” or “balance of Eligible Expense” will be made on a claim-by-claim basis. No savings or credit reserves will be recognized.

ORDER OF BENEFIT DETERMINATION

The rules establishing the order of benefit determination are:

the benefits of a plan which covers the Claimant as an active employee will be determined before the benefits of a plan which covers such Claimant as a non-active enrollee (i.e., a retired or laid off employee, a COBRA enrollee, etc.) or as a dependent. If the Other Plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the Other Plan will prevail;

when Claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:

(i) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or

(ii) if the Other Plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the Other Plan will prevail.

However, when Claimant is a dependent child whose father and mother are legally separated or divorced:

the benefits of a plan which covers the Claimant as a dependent child of the parent with custody will be determined first; OR

if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned-parent's plan will be determined first and the other parent's plan will be determined second;

the plan of the spouse of the parent with custody will be determined next; and

the plan of the parent not having custody of the child will be determined last.

If none of the above rules establish an order of benefit determination, the benefits of the plan which has covered the Claimant for the longer period of time are determined before those of the plan which has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of enforcing or determining the applicability of the terms of this provision of This Plan 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.

SPECIAL PROVISIONS WITH RESPECT TO MEDICARE

Reduction Act (DEFRA - P. L. 98-369), an active Employee or spouse, who has attained age 65 and is eligible for Medicare, may elect or reject medical coverage under This Plan. If such person elects medical coverage under This Plan, the benefits of This Plan will generally be determined before any benefits provided by Medicare (i.e., This Plan will pay its benefits first and then the claims may be submitted to Medicare for consideration). Covered Persons should be certain to enroll in Medicare coverage in a timely manner to assure maximum coverage.

There may be an instance when, in accordance with Federal law, This Plan may assume a secondary position to Medicare (i.e., Medicare will determine its liability first). If this should occur, This Plan reserves the right to assume the secondary carrier position and Plan **benefits will be reduced by benefits paid or payable by Medicare**. In such instance, if the Claimant is eligible for Medicare, he will be deemed to be covered by Medicare parts "A" and "B," whether or not he has actually enrolled for both parts. Also, he will be deemed to be covered by Medicare as of the earliest date any Medicare coverage could have been effective had he applied in a timely manner. Covered Persons should be certain to enroll in Medicare coverage in a timely manner to assure maximum coverage.

NOTE: If a Medicare-eligible Employee rejects coverage under the Plan, no Plan coverage will be available for any of his Dependents.

SUBROGATION AND REIMBURSEMENT PROVISIONS

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:

SUBROGATION, ETC., continued

- 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

Eligibility Requirements - Employees

Unless otherwise agreed in writing between the Plan and a District, in order for an Employee to be eligible to participate in the Plan, he must be in full-time active employment for the Employer as defined by the District and entitled to receive medical and hospital benefits under the Plan. Certain retirees may also be eligible to participate in the Plan in accordance with District guidelines and pursuant to a written agreement.

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 on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section), and as otherwise required by Internal Revenue Code section 4980(H). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

Variable Hour Employees eligible pursuant to the Affordable Care Act – An ACA-Eligible Employee must work a sufficient number of hours over the measurement period selected by their employer District to be considered a "full time employee" under the Affordable Care Act as defined by Internal Revenue Code §4980H(c)(4). An ACA-Eligible employee means an employee who is employed on average at least 30 hours of service per week over the measurement period selected by the District, however that definition shall be updated from time-to-time in accordance with revisions to IRC §4980(H). An ACA-Eligible Employee's eligibility to participate in the Plan begins after the measurement period, and any related administrative period selected by their District, concludes. An ACA-Eligible Employee will be offered coverage to participate in the Plan for the stability period that corresponds to their applicable measurement period.

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 eligibility.

Effective Date - Employees

The Employee coverages of the Plan may be provided on a contributory or non-contributory basis (that is, the Employee may or may not share in the cost of coverage). Subject to completion of the necessary enrollment forms, an eligible Employee's coverage is effective upon completion of the probationary or waiting period requirement established by the District, in accordance with the parameters established by Public Health Safety Act section 2708 and Treas. Reg. section 54.9815-2708(c) as updated from time-to-time.

WARNING: NO EMPLOYEE MAY DECLINE COVERAGE OR FAIL TO ENROLL HIMSELF OR ELIGIBLE DEPENDENTS UNLESS HE IS AN ACA-ELIGIBLE EMPLOYEE OR IS ENROLLED IN OTHER COVERAGE OFFERED BY A PARTICIPATING EMPLOYER DISTRICT (I.E. KAISER), AND COMPLETES AND SIGNS THE "WAIVER NOTICE" FORM PROVIDED BY THE EMPLOYER OR PLAN SPONSOR.

Pursuant to the above warning, only two categories of eligible Employees may opt-out of coverage in this Plan: (1) An ACA-Eligible Employee, or (2) an eligible Employee who is enrolled in other coverage offered by their employer (such as an Employee who work at a participating member district which also offers a Kaiser product and is enrolled in that employer-sponsored group health plan in lieu of this Plan).

Eligibility Requirements - Dependents

Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a legally married spouse. A "spouse" will mean a person of the opposite or same sex as the Employee. "Legally married" means a legal union (as defined by the Employee's state of residence) between one individual and another individual;

a domestic partner, subject to the following criteria:

- the Employee and domestic partner have filed a declaration of Domestic Partnership with the Secretary of State of the State of California;

ELIGIBILITY AND EFFECTIVE DATES, continued

- the Employee and domestic partner must have a common residence (applicable to confidential registered domestic partners only). It is not necessary that the legal right to possess the residence be in both names;
- neither the Employee nor domestic partner may be married to someone else or be a member of another domestic partnership that has not been terminated, dissolved or annulled;
- the Employee and domestic partner must not be related by blood in any way that would prevent them from being married to each other in California;
- both the Employee and domestic partner must be at least 18 years of age;
- both the Employee and domestic partner must be capable of consenting to the domestic partnership; and
- either of the following must be true: (1) the Employee and domestic partner must be of the same sex, or (2) the domestic partner must be of the opposite sex and one or both persons must be over age 62 and also meet the eligibility criteria for Medicare benefits. Effective on and after January 1, 2020, the age requirement for a domestic partner of the opposite sex is lowered to age 18, and the requirement to meet the eligibility criteria for Medicare benefits is removed.
- a child who is under age 26 (i. e., through age 25, including the full month in which the child attains age 26). 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 or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.

An eligible “child” is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted child, a child who is placed with the Employee for legal adoption, a child for whom the Employee has legal guardianship, or a foster child). An eligible child also includes one for whom coverage is required due to a Qualified Medical Child Support Order.

NOTES: An eligible Dependent does not include:

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

any person 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 - Dependents

The Dependent coverages of the Plan may be provided on a contributory or non-contributory basis. A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date (see the "Special Enrollment Rights" provision for details as well as instances when the loss of other coverage can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment / Re-Enrollment" provision.

NOTE: A Dependent's coverage will not become effective prior to the Employee's effective date. Also, see "Newborn Children..." below for special provisions pertaining to newborns.

Newborn Children - Limited Automatic 31-Day Benefit Period

An Employee's newborn child will be eligible for benefits for Eligible Expenses that are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. The child will be covered after the 31-day benefit period only if the child is enrolled within thirty-one (31) days of birth

– see “Entitlement Due to Acquiring New Dependent(s)” in the “Special Enrollment Rights.”

ELIGIBILITY AND EFFECTIVE DATES, continued

NOTE: During the limited 31-day benefit period, a newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options that are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Special Enrollment Rights & Mid-Year Election Change Allowances

An individual who enrolls in accordance with this "Special Enrollment Rights" provision is not a "late enrollee".

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

he was covered under another group health plan or other health insurance coverage (including Medicaid or a State Children's Health Insurance Plan (CHIP)) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage (and within sixty (60) days with regard to Medicaid or CHIP - see last sub-entry below). A loss of coverage event includes but is not limited to:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and
- on or after April 1, 2009, loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or the date the individual becomes eligible for State premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement to Drop Due to CHIP Eligibility - If an Employee's child(ren) become eligible for CHIP (known as "Healthy Families" in California), Employee has the ability to drop the child(ren) from the group health coverage

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the date of marriage;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

Court or Agency Ordered Coverage – In accordance with state and federal law, if the Plan receives a Medical Child Support Order (MCSO) from a state court or agency and such order is determined by the Plan to be a qualified order (QMCSO), the child shall be enrolled as of the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Change in Status, Cost or Coverage – An Employee will be permitted to make Plan election changes when such changes are consistent with and made concurrently with changes allowed under the Plan Sponsor's Section 125 cafeteria plan due to a qualified change as permitted under Federal law. The effective date of the Plan changes will be concurrent with the effective date of the cafeteria plan changes, unless an earlier effective date would be allowed under the terms of one of the other subsections of this "Special Enrollment Rights" provision.

Late Enrollment / Re-Enrollment

If an individual does not enroll when he is first eligible or if he allows coverage to lapse but later re-enrolls, then Plan coverage will be effective as of the date application is made but any such individual will be considered a "late enrollee".

NOTE: See "Special Enrollment Rights" for exceptions to this provision.

Open Enrollment & HMO Transfers

Each Plan Year, a Participating Employer will hold an Open Enrollment Period. At that time, eligible Employees and their eligible Dependents may change from/to any other employer-sponsored coverages from/to the coverages described herein. Such newly-elected coverage will then become effective on the date designated by the Plan Sponsor.

The Open Enrollment Period is also a time when individuals may re-enroll if they voluntarily terminated Plan coverage or allowed Plan coverage to lapse – see "Late Enrollment / Re-Enrollment" on page 43.

Also, each Employee who is covered under the Plan Sponsor's HMO plan when he changes residence out of the

ELIGIBILITY AND EFFECTIVE DATES, continued

HMO service area, transfers to a work location of the Employer that is not serviced by the HMO, or when the HMO discontinues operations for financial or other reasons, may elect to change to this Plan for himself and covered Dependents. A written request for change must be made within thirty-one (31) days of the residence change or HMO discontinuance. Any such coverage under the Plan will become effective on the later of:

the date Employee makes the written request; or

the date of the change in residence or HMO discontinuance of operations.

If Employee fails to request the change within thirty-one (31) days, the "Late Enrollment/Re-Enrollment" or "Special Enrollment Rights" provisions will apply.

NOTE: In accordance with the Health Maintenance Organization Act, any provisions that exclude or restrict benefits for treatment of a sickness or injury that occurred prior to the effective date of the coverage change (i.e., prior to the move from the HMO coverage) will not apply if the treatment would have been covered by the HMO had the individual remained a member of the organization. However, all other provisions, conditions, exclusions and limitations of the Benefit Document will apply.

Reinstatement / Rehire

If an Employee returns to active employment and eligible status immediately following an approved leave of absence taken in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) and during the leave Employee discontinues paying his share of the cost of coverage, then the Employee may have coverage reinstated as if there had been no lapse (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 and the Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

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. See "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.

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. Notwithstanding the foregoing, for the purposes of an ACA-Eligible Employee, the educational organizational rehire rules of Treas. Reg. section 54.4980H-3(c)(4)(ii) shall apply.

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 for coverage as Employees under this Plan, each has the option to enroll eligible Dependents for coverage hereunder. The combined maximum contractual benefits to which both Employees are entitled hereunder will not exceed the aggregate of 100 percent of the Network negotiated rate for the Eligible Expenses. In a service area without Network providers, the combined maximum contractual benefits will not exceed the aggregate of 100 percent of the Usual and Customary and Reasonable charge(s) for the Eligible Expense. See **Coordination of Benefits** section for claims handling procedures.

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 Coverage Termination

Except as noted, an Employee's coverage will terminate upon the earliest of the following:

termination of the Plan or Plan benefits as described herein;

termination of participation in the Plan by the Employee;

the date the Employee becomes a full-time member of the armed forces of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year. For active duty in the military services of the United States such date will be the date of active duty on his/her "activation Orders." However, if the U.S. active duty call-up is for less than 30 days and is then extended, Plan coverage will continue until 12:00 midnight on the 30th day of active duty;

at the end of the period for which Employee 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.

NOTE: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

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.

The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.

Dependent Coverage Termination

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

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

termination of the coverage of the Employee;

the date the Dependent becomes a full-time member of the armed forces of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;

at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan (including the last day of the month in which the Dependent attained age 26), 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;

on the date the Employee requests that Dependent coverage be terminated or at 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.

NOTE: 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.

The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.

- (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.

NOTE: Unless expressly stated otherwise, if a Covered Person is eligible for and elects continuation coverage under the terms of the section entitled **Continuation of Coverage Option (COBRA)**, any Extension of Coverage hereunder will run concurrently with COBRA coverage and WILL NOT operate to extend the COBRA maximum period.

Special Extended Coverage

If circumstances are such that a covered Employee has acquired Medicare, Parts A and B, and COBRA is not available, Special Extended Coverage may be offered by a Participating Employer District to a full-time, active Employee, currently covered under the FASBO/EdCare plans, as part of an incentive package to retire or leave employment. Special Extended Coverage will be for no more than ninety (90) days.

After the Special Extended Coverage period expires, all other eligibility rights found in the Plan will be available if applicable.

Extension of Coverage for Handicapped Dependent Children

If an already covered Dependent child attains age 26, which 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; and

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; 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 26 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 to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such 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 eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave or a temporary layoff), 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 as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

CLAIMS PROCEDURES, continued

on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;

while Employee is absent from work during a temporary leave of absence granted by the member school District from which the Employee is employed;

twelve (12) consecutive months during an approved sabbatical leave of absence;

while Employee is on an non-FMLA employer-approved leave of absence for illness, employment will be deemed to continue provided such Employee's inability to return to work is certified annually by the District;

the end of the period for which the last contribution was paid, if such contribution is required; the date of termination of this Plan.

NOTE: 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 Armed Forces 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 that 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).

To the extent an eligible Employee is entitled to greater continued coverage under the California Family Rights Act (CFRA), than under FMLA, plan benefits may be maintained during CFRA leave at the levels and under the conditions that would have been present if employment was continuous. CFRA allows for leave to care for the additional relatives of grandparent, grandchild, or sibling, and also provides for leave due to qualifying exigency related to military service of a domestic partner. An Employee can obtain a more complete description of his or her CFRA rights from the Plan

CLAIMS PROCEDURES, continued

Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the CFRA are modified to comply with at least the minimum requirements of that act.

Continuity of Care under the No Surprises Act. To the extent required by the No Surprises Act, a Covered Person who is a "continuing care patient" receiving an ongoing course of treatment from a Network Provider at the time that the provider becomes a Non-Network Provider, or at a Network facility at the time that the facility becomes a Non-Network facility, may continue to receive transitional care for up to 90 days on the same terms and conditions that were in place before the transition. A Covered Person is a "continuing care patient" of a Provider or facility if they (a) are undergoing a course of treatment for a "serious and complex condition", (b) are undergoing a course of institutional or inpatient care, (c) are scheduled to undergo nonelective surgery from the provider, including post-operative care for such nonelective surgery, (d) are pregnant and undergoing a course of treatment for the pregnancy, or (d) were determined to be "terminally ill" and are receiving treatment for such illness. As used herein a Covered Person has a "serious or complex condition" if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. As used herein, a Covered Person is "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is six months or less.

Extension of Coverage During Labor Dispute

If an Employee fails to continue in active employment due to a labor dispute (e.g., a strike), Employee can arrange to continue coverage for up to six (6) months. This extension will cease, however, on the earlier of the following:

- at the beginning of the period for which Employee fails to make the required payment toward the cost of coverage to his collective bargaining unit representative;

- at the beginning of the period for which the representative fails to make the required cost of coverage payments to the Plan Sponsor or Contract Administrator;

- on the date Employee commences active employment with another employer;

- on any contribution due date when less than 75% of the affected Employees have elected to continue coverage under the terms of this provision;

- at the end of six (6) months following the cessation of active employment.

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

CLAIMS PROCEDURES, continued

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 is the lesser of: 18

months (or 24 months for elections made on or after December 10, 2004); 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.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

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

When coverage under the Plan 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 Certain Retirees

A Participating Employer District may offer extended coverage options for eligible retirees. The availability and terms and conditions of such extensions are as determined by each District or applicable law, including California Assembly Bill # 528 (AB528). A retiring Employee should contact his District offices for additional information.

Extension of Coverage for Disabled Certificated Employees

If a certificated Employee becomes disabled as result of injuries that are a direct consequence of a violent act and if the Employee receives disability benefits from CalSTRS, a Participating Employer District will offer the disabled Employee the opportunity to enroll in the Plan’s medical benefits. The District may require the Employee to pay the full cost of such coverage. An Employee should contact his District offices for additional information.

- (See *COBRA Continuation Coverage*) -

EXTENSION OF BENEFITS DURING AN EMPLOYEE’S TOTAL DISABILITY

If an Employee is Totally Disabled on the date his coverage terminates, 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;

CLAIMS PROCEDURES, continued

at the end of the year following the year in which the Employee's coverage terminates;

upon the Employee'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;

the date the maximum amount of benefits has been paid.

For these purposes, "Total Disability" or "Totally Disabled" means a disability resulting solely from a sickness, injury or pregnancy that prevents the Employee from engaging in his or her regular or customary occupation. The Employee may not, in fact, be engaged in any employment or occupation for wage or profit and be considered Totally Disabled.

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

NOTE: If an Employee is eligible for and elects continuation coverage under the terms of the section entitled **Continuation of Coverage Option (COBRA)**, this Extension of Benefits will run concurrently with COBRA coverage and WILL NOT operate to extend the COBRA maximum period.

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

CLAIMS PROCEDURES

Proof of Loss

Written proof covering the details of loss for which a health care claim is made must be furnished to the Contract Administrator within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Claimant, later than twelve (12) months from the date on which covered charges were incurred.

Claims should be sent to:

**Delta Health Systems
P.O. Box 527
Stockton, CA 95201-0527**

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

Claims Questions and Adjudication

All claims and questions regarding health claims should be directed to the Contract Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Sponsor decides in its discretion that the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan document have been delegated to the Contract Administrator, however, the Contract Administrator is not a Fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

If the Plan Sponsor in its sole discretion shall determine that the Claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is required, no benefits shall be payable under the Plan.

Assignments to Providers

All Eligible Expenses reimbursable under the health care coverages of 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.

CLAIMS PROCEDURES, continued

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.

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 Denials and Appeal Procedures

If a claim is wholly or partially denied, the Claimant will be given written notification of such denial. This notice will include:

the reason(s) for the denial;

specific reference to the Plan provision(s) on which the denial is based;

a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

appropriate information as to the steps to be taken if a Plan participant wishes to submit the claim for review.

A Claimant may request a review of his claim, provided such request is filed in writing to the Contract Administrator (at the address shown above) within sixty (60) days after the date his claim is denied.

At such time as the Claimant requests a review of the denied claim, he may review any pertinent documents and should submit issues and comments in writing.

The Plan Sponsor will make a decision with regard to the appeal not later than sixty (60) days after the receipt of the request for review, unless special circumstances require an extension of time. If an extension is required, written notice of the extension will be furnished to the Claimant or Employee prior to the termination of the initial 60-day period. The extension notice will explain the special circumstances requiring an extension and the date the Plan Sponsor expects to render the final decision.

The decision on review will be in writing, will include the specific reason(s) for the decision and will reference the pertinent provisions on which the decision is based.

Arbitration

Any claim which cannot be settled by the mutual cooperation of the Covered Person (or his legal representative) and the Plan Sponsor, will be settled by arbitration in accordance with the Employee Benefit Claims Arbitration Rules of the American Arbitration Association, incorporated by reference herein.

In all cases submitted to arbitration, the parties agree to share equally the administration fee as well as the Arbitrator's fee, if any, unless otherwise assessed by the Arbitrator. The Arbitrator's fee shall be advanced by the initiating party, subject to final apportionment by the Arbitrator in his award.

The result of the arbitration will be final and binding on both parties. Judgment upon any award rendered by the Arbitrators may be entered in any court having jurisdiction thereof.

Effective October 1, 2011 and in accordance with Technical Release No. 2011-02, the following claims and review processes will apply.

| |
|--------------------------------------|
| ADVERSE BENEFIT DETERMINATION |
|--------------------------------------|

The Plan must ensure that any notice of an adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its

corresponding meaning).

The Plan must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

The Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

The Plan must disclose the availability of, and contact information for, any applicable office of health coverage consumer assistance or ombudsman established under the Public Health Service Act (section 2793) to assist individuals with the internal claims and appeals and external review processes.

INTERNAL CLAIMS REVIEW 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 Federal 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. In the case of an pre-service urgent care claim, a decision must be made as soon as possible consistent with the medical exigencies involved, but in no event later than 72 hours), provided that the Plan defers to the attending provider with respect to the decision as to whether the claim constitutes "urgent care."

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 the Public Health Service Act;

- 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 Plan Administrator.

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 applicable 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 CLAIMS REVIEW PROCEDURES |
|--|

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer;
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time); and
3. A determination of whether the Plan is complying with the No Surprises Act, as applicable.

Standard external review

Standard external review is external review that is not considered expedited (as described in the “expedited external review” paragraph in this section).

1. **Request for external review.** The Plan will allow a claimant to file a request for an external review with the Plan 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 of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

CLAIMS PROCEDURES, continued

- c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
 - d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility. If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later;
3. **Referral to Independent Review Organization.** The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits; or
 4. **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. **Request for expedited external review.** The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
 - a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns 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.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.
3. **Referral to Independent Review Organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

CLAIMS PROCEDURES, continued

4. **Notice of final external review decision.** The Plan's (or Contract Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will 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 that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Adverse Benefit Determination - Any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.

Ambulatory Surgical Center / Licensed Surgical Facility - 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.

Approved Clinical Trial - a phase I, II, III or IV trial that is federally approved or funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research and Quality, 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), that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone 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. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of-network benefits are otherwise provided under the Plan.

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:

DEFINITIONS, continued

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.

Charitable Research Hospital - A Hospital that:

is internationally recognized as devoting itself primarily to medical research;

expends not less than ten percent (10%) of its operating budget in each fiscal year exclusively on medical research activities that are not directly related to the provision of services to patients;

derives not less than one-third (1/3) of its gross revenues in each fiscal year from contributions, donations, grants, gifts, or other gratuitous forms from individuals, groups, persons, or entities unrelated to the hospital. Contributions, donations, grants, gifts, or other gratuitous sources of revenue received as compensation for medical services provided to patients will not be considered for these purposes;

accepts patients without regard to the patient's ability to pay for medical services;

admits not less than two-thirds (2/3) of its patients with a primary diagnosis or suspected disease or condition directly related to the specific area or areas in which the Hospital conducts research. Patients admitted because of an emergent life-threatening condition who could not be safely transported to another Hospital will not be considered as patients for these purposes.

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 "Skilled Nursing Facility"

Co-Pay - see the **Medical Benefit Summary** for information

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)). 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)

Licensed Clinical Psychologist (PhD or EdD) Licensed Clinical Social Worker (LCSW) 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) Psychiatrist (MD)

Registered Nurse (RN) Respiratory Therapist Speech Pathologist

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

any practitioner of the healing arts who is licensed and regulated by a state or federal agency, is providing services or supplies that are covered hereunder, and is acting within the scope of his license;

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

licensed Outpatient mental health facilities;

freestanding public health facilities;

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

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

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.

Deductible - see the **Medical Benefit Summary** for information

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

- A School District who is participating in the Plan.

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.

NOTE: An Eligible Expense will not include any charge which would have been covered by an HMO on a "primary payor" basis if the patient had used the services of an HMO provider. Nor will this Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

Emergency - see "Emergency Medical Condition" and "Emergency Services".

Emergency Medical Condition - A medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished. These services include those provided at an independent freestanding emergency department as well as a Hospital emergency department. A decision of what constitutes emergency services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

Emergency Services - shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Network Facility (regardless of the department of the Hospital in which items or services are furnished) after the Covered Person is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Covered Person is able to travel using non-medical transportation or non-emergency medical transportation, and the Covered Person is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

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.

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

Final Adverse Benefit Determination - an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Home Health Care Agency - An agency or visiting nurse association which is licensed by the State of California, is certified with the Secretary of Health and Human Services of the United States for participation under the Medicare Act, and which provides skilled nursing services and other services on a visiting basis in the patient's home and is

DEFINITIONS, continued

responsible for administering a home health care program and supervising the delivery of such services under a plan of home health care prescribed and approved in writing as part of the medical record of the member by the attending Physician and surgery.

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 which:

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

has a Physician on call at all times;

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

facilities for diagnosis of injury or disease;

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

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

A "Hospital" will also include any facility operating legally as a psychiatric hospital and licensed as such in the state in which it operates.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Skilled Nursing Facility) 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.

Medically Necessary - Any health care treatment, service or supply determined by the Plan 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;

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

DEFINITIONS, continued

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 & D 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 plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor - The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. 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.

Reasonable – 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

DEFINITIONS, continued

“reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

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 - Sickness will mean bodily illness or disease (including covered mental health conditions and covered substance use disorders), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - An institution that:

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, 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 nursing home, a hotel, a school or a similar institution, 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, or for the care of senile persons.

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 and Customary - Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

DEFINITIONS, continued

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices;

GENERAL PLAN INFORMATION

| | |
|---|---|
| Name of Plan: | The EdCare Group Health Benefits Plan |
| Plan Sponsor / Plan Administrator: | Fresno Area Self-Insurance Benefits Organization Joint Powers Agreement, dba: The EdCare Group |
| Participating Employer(s): | School Districts who are participating in the Plan |
| Plan Year: | October 1 through September 30 |
| Privacy Officer / Contact Person: Phone Number: | Kingsburg Charter School District, Benefit Specialist (559) 897-2331 |
| Plan Benefits Described Herein: | Self-Funded Medical and Prescription Benefits |
| Type of Administration: | Contract Administration – see “Administrative Provisions” for additional information |
| Contract Administrator: Address: | Delta Health Systems 3244 Brookside Road Stockton, CA 95201 |
| Phone: | (209) 474-5587 or (800) 291-0726 |

FUNDING - SOURCES AND USES

Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Sponsor will, annually, evaluate the costs of the Plan and determine the amount to be contributed (if any) by each enrollee (i.e., Employee, retiree, Dependent, COBRA enrollee)

ADMINISTRATIVE PROVISIONS

Administration (type of)

The Plan benefits described herein 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:

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; 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.

Culturally and Linguistically Appropriate Notices

A Plan having participants in a county with a certain percentage of non-English language speakers (based on data published by the U.S. Census Bureau) must inform Claimants residing in such county as to how they may obtain language assistance services. The Plan must inform such persons by including a statement, in the applicable foreign language, on all claim and appeal notices.

Before issuing an adverse benefit determination (i.e., a claim denial), the Plan shall check the list of counties to see if the notice will be required

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.

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 management 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 which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

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 in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

GENERAL PLAN INFORMATION, continued

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 being the victim of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Notice of Privacy Practices – THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Permissible uses and disclosures:

The EdCare Group (Plan) may use your health information, that is, information that constitutes protected health information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of arranging for your treatment, making or obtaining payment for your care and conducting health care operations.

The follow is a summary of how your health information may be used and disclosed:

For Treatment. The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the Plan may disclose that you are eligible for benefits to a health care provider who contacts the Plan to verify your eligibility.

To Make or Obtain Payment. The Plan will use or disclose your PHI to pay claims for services provided to you. For example, the Plan may contact another health plan to coordinate your benefits.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. For example, the Plan may use your health information to engage in customer service and appeal services.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability; Prevent or reduce a serious threat to your health or safety.

For Disclosure to the Plan Sponsor. The Plan may disclose your health information to the Plan Sponsor for plan administration functions performed by the Plan Sponsor on behalf of the Plan. The Plan also may provide summary health information to the Plan Sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

GENERAL PLAN INFORMATION, continued

When Legally Required. The Plan will disclose your health information when it is required to do so by any federal or state law to ensure the Plan's compliance with privacy laws.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state or federal law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.

For Law Enforcement Purposes. As permitted or required by state or federal law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. Any disclosure would be to someone able to help prevent the threat.

For Specified Government Functions. In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

For Worker's Compensation. The Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

For Underwriting and Related Purposes. The Plan may use or disclose your health information for the purposes of underwriting, premium rating, or other activities relating to the creation, renewal or replacement of health insurance, but is prohibited from using or disclosing your genetic information for such purposes.

Authorization to use or disclose PHI.

Designate Someone to Act on Your Behalf. You may have someone contact the Plan and exercise your rights on your behalf by completing a Designation of Authorized Representative form. This form should be completed whenever you wish to have your spouse or other personal representative call the Plan. You may obtain the form by calling Delta Health Systems at the number shown on your Plan ID card or visiting Delta's website at deltahealthsystems.com. You may mail the form, or other legal document such as a power of attorney, to the address shown on the form.

Other than the activities described in this Notice, the Plan generally will not disclose your health information unless you have designated someone to act on your behalf. If you are not able to tell the Plan your preference, for example if you are unconscious, the Plan may share your information if it is in your best interest.

The Plan must obtain your authorization before using or disclosing your health information for marketing purpose or sells your information to a third party.

If you authorize the Plan to use or disclose your health information, you may revoke that authorization at any time by writing to Delta Health Systems.

Your rights:

You have the following rights regarding your health information that the Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Plan's Privacy Officer at the address shown under the "Contact Person – Privacy Officer" section of this Notice.

Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Plan's Privacy Officer at the address shown under the "Contact Person – Privacy Officer" section of this Notice. The Plan will attempt to honor your reasonable requests for confidential communications.

GENERAL PLAN INFORMATION, continued

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made by calling Delta Health Systems at the number shown on your Plan ID card. Delta will provide a copy or a summary of your health and claim records, usually within 30 days of your request. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the Plan maintains the information. A request for an amendment of records must be made in writing to Delta Health Systems at PO Box 80, Stockton, CA 95201. The Plan will respond to your request in writing within 60 days. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to obtain a list of certain disclosures the Plan has made of your protected health information. This is often referred to as an "accounting of disclosures." You can ask for an accounting of the times the Plan has shared your health information in the last six years prior to the date you asked, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make to a designated representative.) If you want to exercise this right, your request to the Plan must be in writing to Delta Health Systems at PO Box 80, Stockton, CA 95201. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Notification of Breach of Unsecured PHI. If PHI that the Plan or any of its business associates uses or discloses is breached and the result is a compromise of the privacy or security of your PHI, you will be notified in writing.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Plan's Privacy Officer at the address shown under the "Contact Person – Privacy Officer" section of this Notice.

Duties of the Plan.

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice, provide to you this Notice of its duties and privacy practices and to notify you following a breach of your unsecured health information. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

File a complaint.

You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Privacy Officer at the address shown under the "Contact Person – Privacy Officer" section of this Notice. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Privacy Officer

The contact person for issues concerning your privacy rights is the Kingsburg Charter School District, Benefit Specialist who may be reached at (559) 897-2331. You may also contact Delta Health Systems at number on your ID card and ask to speak with their Privacy Officer.

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 scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules, Security Standards & Breach Notification Rules

To the extent required by law, the Plan is amended and will comply with: (1) 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) the HIPAA Security Standards with respect to electronic Protected Health Information.

HIPAA’s Privacy Rules and Security Standards apply to group medical and dental benefits.

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.

The 2009 breach notification regulations and the Health Information Technology for Economic and Clinical Health (HITECH) Act, require HIPAA covered entities and their business associates to provide notification to an affected individual following a breach of unsecured protected health information. Such individual notification must be provided within a reasonable period of time and in no case later than 60 days following the discovery of a breach. To the extent possible, such affected individual must also be provided with a description of the breach, a description of the types of information that were involved in the breach, the steps the individual should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity. More information is available on the U.S. Department of Health & Human Services’ website.

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.

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.

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.

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.

Type of Plan

This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible Employees of the Employer(s), their eligible Dependents, and Qualified Beneficiaries under COBRA.

This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan which, for the most part, is exempt from the requirements the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The

GENERAL PLAN INFORMATION, continued

Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, 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, this Plan intends to fully comply with the above-stated federal laws.

This Plan is subject to the terms of collective bargaining agreement(s). A complete list of the bargaining units participating in the Plan may be obtained upon written request to the Plan Sponsor, and is available for examination by Covered Person and beneficiaries at the office of the Plan Sponsor. Covered Persons and beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular employee organization is participating in the Plan and, if the organization is participating, the address of such entity.

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 or loss of Dependent child eligibility), 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 Responsibilities – 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, or the unavailability of COBRA 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.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

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 **COBRA**

Notification Procedures as included in the Plan's Summary Plan Description (and 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.

COBRA CONTINUATION COVERAGE, continued

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.

COBRA CONTINUATION COVERAGE, continued

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.

COBRA CONTINUATION COVERAGE, continued

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

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 or limitation with respect to any pre-existing condition 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 Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

COBRA CONTINUATION COVERAGE, continued

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.

NOTICE TO TERMINATE EMPLOYEES IN CALIFORNIA

The California Department of Health Services will pay the private health insurance premiums for certain persons losing employment under the circumstances described below.

State of California Health Insurance Premium Program (HIPP)

The California Department of Health Services may pay the group health coverage costs, under the Health Insurance Premium Program (HIPP), for certain persons losing employment. This program applies to certain Medi-Cal beneficiaries who:

- 1) have a Medi-Cal share-of-cost of \$200 or less;
- 2) have a high cost medical condition for which the average monthly cost is twice the amount of the monthly health insurance premium;
- 3) have current health insurance coverage, or a COBRA continuation or a conversion policy in effect or available;
- 4) have filed an application in a timely manner, allowing sufficient time to process the application and begin the payment of the cost of coverage;

You do not qualify if:

- 1) you qualify for Medicare;
- 2) you are enrolled in a Medi-Cal related pre-paid health plan, San Mateo County Health Plan, Santa Barbara County Health Initiative, or a County Medical Service Program.

To enroll in HIPP or to inquire about requirements, call this toll-free number: 1-800-952-5294 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Persons Disabled by HIV/AIDS

Under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Action of 1990, persons unable to work because of disability due to HIV/AIDS and who are losing their health coverage may qualify for the Health Insurance Continuation Program (CARE/HIPP) provided they:

- 1) are currently covered by a health insurance plan which includes coverage for outpatient drug prescriptions, and then can be converted to a COBRA/OBRA plan;
- 2) have a total monthly income below 250 percent of poverty (i.e. approximately \$1,500 monthly for a single person in 1992).

For additional information on CARE/HIPP, please call the AIDS Hotline:

Northern California: 1-800-367-2437 (English/Spanish)

Southern California 1-800-922-2437 (English)
1-800-922-2438 (Multi-Language)

FOR ADDITIONAL ASSISTANCE BEYOND THAT WHICH IS ADMINISTRATIVELY AVAILABLE
THROUGH YOUR DISTRICT OFFICE, YOU MAY CALL ON THE FOLLOWING:

BROKERAGE OFFICE

BARTHULI & ASSOCIATES
5250 N. PALM AVE., SUITE 403,
FRESNO, CA 93704

PH: (559) 385-7510
FAX: (559) 554-9053

CLAIMS ADMINISTRATION

DELTA HEALTH SYSTEMS
P. O. BOX 527
STOCKTON, CA 95201-0527

PH: (209) 948-8483 or
(800) 422-6099 (toll-free)