
# CENTRAL UNIFIED SCHOOL DISTRICT

## BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

## HEALTH CARE BENEFITS

**NOTE: THESE BENEFITS ARE PART OF THE MEDICAL, DENTAL, VISION AND PRESCRIPTION PLAN FOR THE EMPLOYEES OF CENTRAL UNIFIED SCHOOL DISTRICT**

REVISED & RESTATED: December 1, 2015

**Employee Benefits Consultant:**

DLR INSURANCE SOLUTIONS
7110 N FRESNO, STE 430
FRESNO · CA · 93720
559-435-5725

**Contract Administrator:**

ADVANTEK BENEFIT ADMINISTRATORS
7370 N PALM AVE, STE 101
FRESNO, CA 93711
866-556-7655

# IMPORTANT PHONE NUMBERS

The following providers render services on behalf of the Plan. A COVERED PERSON can contact the appropriate office when he has a question or needs help.

| TYPE OF PROVIDER | IDENTITY OF PROVIDER |
|---|---|
| **Contract Administrator**<br>Address:<br><br>Phone: | **Advantek Benefit Administrators**<br>P.O. Box 45007<br>Fresno, CA 93710<br>(866) 556-7655 |
| **Plan Benefits Specialist**<br>Phone:<br>Email: | **Mary Romero, District Annex**<br>(559) 274-4700, ext. 63103<br>mromero@centralusd.k12.ca.us |
| **Plan Consultant**<br>Address:<br><br>Phone:<br>Email: | **DLR Insurance Solutions**<br>7110 N. Fresno, Suite #430<br>Fresno, CA 93720<br>(559) 435-5725<br>www.doug@dlris.com |
| **Utilization Review Center**<br>Phone # for Fresno County:<br>Phone # for All Counties except Fresno: | **Advantek Benefit Administrators**<br>(866) 556-7655<br>(800) 274-7767 |
| **PPO Network Status / Provider Finder**<br>Phone:<br>Email: | **Anthem Blue Cross**<br>(800) 649-9121<br>www.tpa.anthem.com |
| **Pharmacy Benefit**<br>Phone:<br>Email: | **Caremark/Advance PCS**<br>(888) 665-6759<br>www.caremark.com/wps/portal |
| **Managed Behavioral Health**<br>Phone:<br>Email:<br>(Provides Outpatient or Inpatient services for mental & nervous/substance abuse. 24 hours/7 days a week) | **The Holman Group**<br>(800) 321-2843<br>www.Holmangroup.com |
| **Employee Assistance Program**<br>Phone:<br>Email:<br>(Provides confidential assistance for psychological & substance abuse problems. 24 hours/7 days a week) | **The Holman Group**<br>(800) 321-2843<br>www.Holmangroup.com |
| **Chiropractic Care**<br>Phone:<br>Website: | **ChiroMetrics, Inc.**<br>(877) 519-8839<br>www.chirometrics.com |

# SCHEDULE OF LIFE AND AD&D BENEFITS

| | Life Insurance* | Accidental Death & Dismemberment* |
|---|---|---|
| Participants below age 65 | $10,000 | $10,000 |
| Dependents, over 6 months of age | $ 1,000 | |
| Under age 6 months | $ 100 | |

Participant insurance reduces by 35% at age 65, and by 50% at age 70.

*Not available to COBRA Participants or surviving spouses.

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# IMPORTANT NOTICES

This is a self-funded benefit plan coming within the purview of the Employee Retirement Security Act of 1974 ("ERISA"). As such, when applicable, Federal law and jurisdiction preempts State law and jurisdiction.

## WHO TO CONTACT FOR ADDITIONAL INFORMATION

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

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## COBRA NOTICE PROCEDURES

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

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

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

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## 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 (see **NOTE**), 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).

**NOTE: An "attending provider" does not include a plan, hospital, managed care organization or other issuer.**

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## 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.

Covered Persons 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).

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## GENETIC INFORMATION AND NON-DISCRIMINATION ACT

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

## DEFINITIONS

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

## SOLICITUD DE INFORMACIONES EN ESPAÑO (SPANISH LANGUAGE OFFER OF ASSISTANCE)

ESTE DOCUMENTO ESTÁ ESCRITO EN INGLES Y CONTIENE UN RESUMEN DE LOS DERECHOS Y BENEFICIOS DE SU PLAN DE SEGURO. SI UD. TIENE DIFICULTAD EN COMPRENDER CUALQUIER PARTE DE ESTE DOCUMENTO, COMUNIQUES:

**Central Unified School District**
4605 North Polk Avenue
Fresno, CA 93722

EL HORARIO DE LA OFICINA ES: LAS OCHO DE LA MAÑANA HASTA LAS CUATRO DE LA TARDE, LUNES A VIERNES. UD. TAMBIEN PUEDE LLAMAR A LA OFICINA DEL ADMINISTRADOR DEL PLAN DE SEGURO A ESTOS TELÉFONOS: (559) 274-4700 PARA PEDIR AYUDA.

# UTILIZATION MANAGEMENT PROGRAM

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

## PRIOR AUTHORIZATION REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide prior authorization. To obtain authorization call:

Fresno County: (866) 556-7655
All Other Counties: (800) 274-7767

**NOTE: To obtain authorization for Mental Health and Substance Abuse benefits (Outpatient or Inpatient), an individual must contact The Holman Group at 1-800-321-2843.**

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

Inpatient Admission - Except as noted, prior to any non-emergency admission to a Hospital or Skilled Nursing Facility (including an admission for mental health and substance abuse or acute rehabilitation), the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization. For an emergency admission, the Utilization Management Organization must be contacted within 24 hours after admission or by the end of the first business day following admission. An emergency admission is one that involves the sudden onset of severe medical symptoms that: (1) could not have been reasonably anticipated, (2) require immediate medical treatment, or (3) can be considered life-threatening.

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

**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.**

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

Durable medical equipment where the cost will exceed $500
Home health care
Home infusion (IV) therapy
Potentially cosmetic/investigative services
TMJ appliances
Intensity Modulated Radiation Therapy
Complex Diagnostic Imaging performed on an outpatient basis and on a non-emergency basis, such as CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and Ultrasound.

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

Rehabilitative Counseling Services - The Utilization Management Organization must be contacted for authorization prior to the performance of any rehabilitative counseling services ordered for the same condition more than once every twelve months.

**Penalty for Non-Compliance** - For all medical services requiring prior authorizations not mentioned elsewhere, an additional $250 Co-Pay will be applied after Plan benefits are determined.

If the prior authorization requirements are not completed for Home Health Care or Home Infusion Therapy the Plan's normal benefits may be reduced or denied if the services are not determined to be Medically Necessary.

Failure to obtain a prior authorization for a proposed transplant may result in no Plan benefits being available for the procedure or any related services or supplies.

Failure to obtain authorization for a Complex Diagnostic Imaging will result in a 50% benefit reduction.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or Allowable Charges of the Plan.

See "Prior Authorization" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

**NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under extraordinary circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).**

**If a Covered Person is not admitted or does not receive a service that has undergone prior authorization within ninety (90) days of the review, or if the nature of the services change, a new prior authorization is required.**

## MORE INFORMATION ABOUT PRIOR AUTHORIZATION

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

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

## CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

The Utilization Management Organization will evaluate and summarize the patient's continuing 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.

Human organ and tissue transplant services require the use of Case Management. Failure to comply with Case Management services may result in a denial of benefits.

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

IMPORTANT: CERTAIN SERVICES MAY REQUIRE AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

# MEDICAL BENEFIT SUMMARIES

## DETERMINATION OF PAID MEDICAL PLAN BENEFITS

**Determination of Covered Expenses and Medical Necessity**
Subject to the exclusions, conditions and limitations stated in the Benefit Document, the Plan will pay benefits to, or on behalf of, a Participant for covered medical expenses up to the maximums specified.

The Plan will pay benefits for the Negotiated Fee Rate or Usual, Customary and Reasonable charges for services and supplies, which are ordered by a Physician. Services and supplies must be furnished by an eligible Provider and be Medically Necessary. Covered Expense is limited to those charges that are necessary to prevent, diagnose or treat disease, defect or injury. All payments made under this Plan for allowable charges will be limited to Usual, Customary and Reasonable charges and/or Negotiated Fee Rate.

The fact that a procedure or level of care is prescribed by a Physician does not mean that it is Covered Expense under the Plan and shall not bind the Plan in determining the liability under the Plan. Services which are not Covered Expense shall include, but are not limited to:

- Procedures that are experimental, of unproven value or of questionable current usefulness;
- Procedures that tend to be redundant when performed in combination with other procedures;
- Procedures that are unlikely to provide a Physician with additional information when they are used repeatedly;
- Procedures that can be performed with equal efficiency at a lower level of care.
- Procedures, treatment or services that are unlikely to improve the patients condition based on either previous behavior or non-cooperation of patient, parent(s) or Guardian(s) of patient if patient is a minor.

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

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with this Benefit Document. Benefits will be paid for the reimbursement of Covered Expense incurred by the Participant if all provisions mentioned in this Summary Plan Description and the Plan Document are satisfied. The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion. Covered Expense will be no more than the Usual, Customary and Reasonable charges or Negotiated Fee Rate as determined by the Plan. Covered Expense is subject to the exclusions, conditions and limitations stated within this Benefit Document. Services and supplies must be ordered and furnished by an eligible Provider and be Medically Necessary.

In determining Medical Necessity, the Plan may choose to utilize any of the following:

- Anthem Blue Cross
- Advantek Benefit Administrators
- The Holman Group
- Medicare
- Standard Accepted Medical Practice
- Other Third Party Experts and Professionals within the medical field of the provided services.

All Medical Necessary determinations will be made on a non-discriminatory basis and will be consistently applied to all Participants with the same medical symptoms, diagnosis, and history.

## GOLD PLAN
## CHOICE OF PROVIDERS

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

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

The Plan Sponsor will automatically provide a Covered Person 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.

It is a Covered Person's responsibility, both personally and financially, to verify a provider's status (Network or Non-Network) for care at or from:

a provider he selected or was referred to at a specified location, because some providers participate at one location, but not at others;

a Physician who will be providing care;

a Hospital or other facility.

Although there may be circumstances when a Network provider cannot be used, Non-Network providers will be paid at the Non-Network benefit levels **EXCEPT** as follows:

Emergency Care for In-Area Residents - If a Covered Person has a Medical Emergency and must use the services of Non-Network providers, any such expenses will be paid at the Network benefit levels. This allowance will also apply when an in-area resident is traveling outside of the Network service area.

No Choice of Provider - If, while receiving covered treatment in a Network Hospital, 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.

Unavailable Services - If, after thorough evaluation by the Plan, it is determined that services of a Non-Network provider specialist are necessary because the needed specialty is not represented in the Network or is not reasonably accessible to the patient due to geographic constraints, such Non-Network specialist care will be covered at the Network benefit levels.

For those benefits where it does not specifically indicate a Network versus a Non-Network level of benefits, the Plan will pay benefits at the Non-Network levels applied to Usual and Customary allowances, except as follows:

Accident-Related Expenses - If a Covered Person requires care for an Accidental Injury, the first $500 of any such expenses will be paid at 100% of the Network Negotiated Rate or the Non-Network Usual and Customary allowances. Allowable Charges must be incurred within 90 days of the accident. Please refer to the "Schedule of Medical Benefits" for additional information about this benefit.

Diagnostic Testing, Outpatient - The Plan will pay for 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 at 100% of the Network Negotiated Rate or the Non-Network Usual and Customary allowances. Requires prior authorization.

Hearing-Related Services & Supplies - If a Covered Person requires a hearing evaluation or hearing aid, the Plan will pay for such expenses at 50% of the Network Negotiated Rate or the Non-Network Usual and Customary allowance up to a maximum of $1,000 in any five (5) year period. Please refer to the "Schedule of Medical Benefits" for additional information about this benefit.

Home Health Care - Home Health Care benefits provide benefit payments at 100% of the Network Negotiated Rate or the Non-Network Usual and Customary allowances, limited to a maximum of 100 visits per Calendar Year.

A Home Health Care Plan must be established in writing by the attending Physician of the Covered Person, and reviewed and approved through the **Utilization Management Program** procedures explained in this booklet. The attending Physician must certify that the Home Health Care Plan is for the same medical condition and that the proper treatment of the condition would require hospitalization in the absence of services provided under the Home Health Care Program.

The following items and services, and no others, are covered by this benefit:

- Part-time or intermittent skilled nursing services provided by a Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse;
- Part-time or intermittent Home Health Aid Services which provide supportive services in the home under the supervision of a Registered Nurse or a Physical, Speech, Occupational Therapist, or Audiologist;
- Physical, Speech, or Occupational Therapy;
- Medical supplies, drugs, and medicines prescribed by a Physician, and related pharmaceutical and laboratory services, to the extent they would have been covered under this Plan if the Covered individual had been in the hospital;
- Social work performed by a Licensed Clinical Social Worker;
- Nutrition services performed by a Licensed Nutritionist; special meals prescribed under the Home Health Care Plan.

**NOTE: Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.**

Pre-Admission Testing - The Plan will pay for outpatient laboratory and X-ray tests prescribed by the attending doctor and required for inpatient admission and scheduled within thirty days of such admission at 100% of the Network Negotiated Rate or the Non-Network Usual and Customary allowances.

Preventive Care - Except as exceeded by the Federally-Required Preventive Care benefits (see the **Appendix for Federally-Required Preventive Care Benefits**), the Plan will pay preventive care as follows:

well child care (up to age 19) - The Plan provides benefits for covered dependents to age nineteen (19) at 100% of the Network Negotiated Rate or 50% of the Non-Network Usual and Customary allowances for a routine or an annual physical examination, including X-rays or laboratory testing services ordered by the examining physician and for inoculations, vaccines and the well child exams required to give these vaccines (this includes sports physicals);

a routine physical exam (age 19 and above) - The Plan provides benefit payments at 100% of the Network Negotiated Rate or the Non-Network Usual and Customary allowances for a routine annual physical examination.

Second Surgical Opinion - The Plan will pay for the second surgical consultation at 100% of the Network Negotiated Rate or 50% the Non-Network Usual, Customary and Reasonable (UCR) allowances. This benefit includes the examination and consultation only and must be performed within one month of the surgeon's recommendation for surgery. The specialist must not be a part of the medical group as the first opinion surgeon and cannot perform the prescribed surgery.

## GOLD PLAN
## SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the schedule reflect the amounts the Plan pays of Allowable Charges after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the Negotiated Rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

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

NOTE: The Gold Plan is available to Employee, Eligible Spouse and Dependent Children to Age 26 (See "Eligibility" section and "Definitions" for further details.

| **LIFETIME / ANNUAL MAXIMUMS** | |
|---|---|
| Lifetime Maximum Benefit | Unlimited |
| Annual Maximum Benefit – see **NOTE** | Unlimited |

Lifetime dollar limits are not allowed for "essential health benefits."

**NOTE: Where annual dollar limits may be applied in a schedule entry, below, the Plan Sponsor has determined that the benefit is not an essential health benefit.**

| **CALENDAR YEAR DEDUCTIBLES** | |
|---|---|
| Individual Deductible | $200 |
| Family Maximum Deductibles | Three |

Individual Deductible - 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.

Family Maximum Deductible - 3 Individual Deductibles must be satisfied during a Calendar Year before the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

Eligible Expenses that are applied toward the Deductible in the last 3 months of a Calendar Year, will also be carried forward and applied to the Deductible for the following Calendar Year.

**NOTE: Where "†" appears in this schedule, it means that the Calendar Year Deductible does not apply.**

| **OUT-OF-POCKET MAXIMUMS** | |
|---|---|
| **Out-of-Pocket** Maximum | $2,250 |
| Family **Out-of-Pocket** Maximum | $4,500 |

Out-of-Pocket Maximum - Except as noted, once a Covered Person incurs more than $2,250 in any Calendar Year in Allowable Charges, the benefits payable by the Plan will increase to 100% for the balance of the Calendar Year. See **NOTE** below for those benefits that are not included when calculating Allowable Charges.

Family Out-of-Pocket Maximum - Except as noted, once a covered family (Employee and his Dependents) incurs more than $4,500 in any Calendar Year in Allowable Charges, the benefits payable by the Plan will increase to 100% for the balance of the Calendar Year. See **NOTE** below for those benefits that are not included when calculating Allowable Charges.

**NOTE: The Out-of-Pocket Maximums do not apply to or include:**

**expenses that are not covered by the Plan;**

**amounts in excess of the Non-Network UCR allowance for Non-Network services;**

**expenses that are paid by the Plan at 100%;**

**expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.**

| **ELIGIBLE MEDICAL EXPENSES** | **Network** | **Non-Network** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply.**<br>**Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service**. | | |
| **Accident-Related Expenses**<br>First $500 per Accidental Injury<br>Thereafter | <br>100%†<br>85% | <br>100%†<br>50% |
| Allowable Charges must be incurred within 90 days of the Accidental Injury. | | |
| **Acupuncture** | 85% | 50% |
| Covered for pain management only. Must be prescribed by a Physician & services must be performed by a Board Certified Acupuncturist. | | |
| **Allergy Injections & Treatment**<br>Injections<br>Office Visit for Allergy Treatment | <br>85%<br>$60 Co-Pay†, 70% | <br>50%<br>50% |
| **Ambulance** | 80% | 80% |
| **Ambulatory Surgical Center** | 100%† | 50%† |
| Allowable Charges include the facility, surgeon, assistant surgeon, anesthesiologist, or certified nurse anesthetist. Requires prior authorization – see "Outpatient Surgery" in the **Utilization Management Program**. | | |
| **Anesthesia** | (see "Physician Services") | |
| **Birthing Center** | 100%† | 50%† |
| **Chiropractic Care**, per visit | $15 Co-Pay† | No Benefits |
| Limited to 30 visits per Calendar Year. Children under age 18 must have a Physician referral. The "Network" for chiropractic care is ChiroMetrics, Inc. See the **Important Phone Numbers** section for contact information or to locate a Network provider. | | |
| **Contraceptives** | (see "Preventive Care Appendix") | 50% |
| **Diabetes-Related Services & Supplies**<br>Self-Management Training & Education, per visit<br>Diabetic Equipment & Supplies | <br>$60 Co-Pay†, 70%<br>85% | <br>50%<br>50% |
| Self-management training and education is limited to 4 day-care days per 24-month period. | | |
| **Diagnostic Testing, Outpatient**<br>Pre-Admission Testing<br>Outpatient (non-pre-admission) Services | <br>100%†<br>100%† | <br>50%†<br>50%† |
| **NOTE: Prior authorization is required for complex diagnostic Imaging or a 50% benefit reduction will apply for failure to pre-certify.** | | |
| **Durable Medical Equipment (DME)** | 85% | 50% |
| Review by the **Utilization Management Program** is required for all DME over $500. | | |

| **ELIGIBLE MEDICAL EXPENSES** | **Network** | **Non-Network** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply.** | | |
| **Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.** | | |
| **Hearing-Related Services & Supplies** | | |
| Hearing Screenings / Evaluations and Hearing Aids | 50%† | 50%† |
| Limited to a maximum of $1,000 In benefits per 5-year period (hearing evaluation / screening included within this maximum) and not to exceed 1 hearing aid per ear every 5 years. | | |
| A referral from an Ear Specialist (ENT, etc.) and a letter of Medical Necessity prior to treatment is required. Must be a non-conductive hearing loss with a PTA greater than or equal to 30db or a discrimination score of less than 76%. Conductive hearing loss at the discretion of an ENT only (based on Medical Necessity). | | |
| **Home Health Care** | 100% | 50% |
| Home Health Care includes home health visits and home visits for infusion therapy and injectables. | | |
| Home Health Care is limited to 100 visits per Calendar Year. Each visit by a nurse or by a therapist will count as 1 visit and each home health aide visit of 4 hours or less will count as 1 visit. | | |
| **NOTE: Requires prior authorization – see the Utilization Management Program**. | | |
| **Hospice Care** | 80% | 80% |
| Limited to a maximum benefit of $10,000 per Lifetime. | | |
| **Hospital Services** – see **NOTES** | | |
| Inpatient Care | 85% | 50% |
| Emergency Room Use: | | |
| with subsequent admission | 85% | 85% |
| without subsequent admission | 85%, less a $100 Co-Pay | 85%, less a $100 Co-Pay |
| Outpatient Surgery (e.g., surgery, anesthesia) | 100%† | 50% |
| Other Outpatient Services & Supplies | 85% | 50% |
| Urgent Care Center Services & Supplies | 85%, less a $100 Co-Pay | 50%, less a $100 Co-Pay |
| Allowable Charges for Inpatient room and board are limited: (1) at a Network Hospital, to the Network Negotiated Rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see **Definitions**) or the Usual and Customary charge for an Intensive Care Unit. | | |
| **NOTES: Inpatient admission requires prior authorization – see the Utilization Management Program. Outpatient surgery requires prior authorization by the Plan Administrator.** | | |
| **Emergency services are covered at the Network benefit levels, regardless of whether a Network provider is used.** | | |
| **Mental Health Care / Substance Use Disorder Care** | | |
| Inpatient Care, Residential & Partial Day Care | 85% | 50% |
| Emergency Room Care: | | |
| with subsequent admission | 85% | 85% |
| without subsequent admission | 85%, less a $100 Co-Pay | 85%, less a $100 Co-Pay |
| Other Outpatient Care | 85% | 50% |
| Outpatient Visits, per visit (visit only) | $25 Co-Pay† | 50% |
| Mental health care and Substance Use Disorder Care is managed by **The Holman Group** – see **NOTE** | | |
| 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 | | |

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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. Also, "covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements).

Holman reimbursement for Out-of-Network Substance Use Disorder Care is the UCR determined using DRG's for higher levels of care and 125% of RVS for professionals, not to exceed provider's billed charges. Patient is responsible for difference between provider's billed charges and Holman reimbursement.

**NOTE: To obtain authorization for Mental Health and Substance Abuse benefits (Outpatient or Inpatient), an individual must contact The Holman Group at 1-800-321-2843.**

| **ELIGIBLE MEDICAL EXPENSES** | **Network** | **Non-Network** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply. Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.** | | |
| **Physician Services** | | |
| Office Visits, per visit (visit only) | $25 Co-Pay† | 50% |
| Outpatient Surgery, Outpatient | 100%† | 50% |
| Anesthesia | 85% | 50% |
| Other Services (Inpatient visits, surgeon, anesthesia, etc.) | 85% | 50% |
| **Pre-Admission Testing** | (see "Diagnostic Lab & X-Ray, Outpatient" above) | |
| **Pregnancy Care** | (benefits are based on the types of services provided – see "Physician Services" and "Hospital Services" for example) | |
| Pregnancy coverage is limited to Employees and spouses. | | |
| **Prescription Drugs, Outpatient** | (see **Prescription Benefit Summary**) | |
| **Preventive Care** | | |
| Federally-Required Preventive Care Services | 100%† | 50% |
| **Other Preventive Care Services** (to the extent they are not included in the Federally-Required Services): | | |
| Routine Physical Exams age 19 and older | 100%† | 50% |
| Well Child Care up to age 19 (Includes sports physicals, visits, inoculations & vaccines) | 100%† | 50% |

Federally-Required Services: (see **Appendix for Federally-Required Preventive Care Benefits**)

- services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force;
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- for infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- for women, additional preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

| **ELIGIBLE MEDICAL EXPENSES** | **Network** | **Non-Network** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply.**<br>**Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.** | | |
| **Second Surgical Opinion** | 100%† | 50%† |
| **Skilled Nursing Facility, Rehab. & Residential Center**<br>First 30 Days<br>Next 30 Days | <br>80%<br>50% | <br>80%<br>50% |
| Allowable Charges for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 60 days per Calendar Year.<br>Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery.<br>**NOTE: Requires prior authorization – see the Utilization Management Program**. | | |
| **Sterilization Procedures** | (benefits are based on the types of services provided – see "Physician Services" and "Hospital Services" for example) | |
| **Substance Use Disorder Care** | (see "Mental Health Care / Substance Use Disorder Care" above) | |
| **Therapy, Outpatient** (occupational, physical, respiratory & speech) | 85% | 50% |
| Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery. | | |
| **Transplant-Related Expenses** | (benefits are based on the types of services provided – see "Physician Services" and "Hospital Services" for example) | |
| **NOTE: A proposed transplant requires prior authorization – see the Utilization Management Program.** | | |
| **Urgent Care Facility**, non-Hospital, per use | $25 Co-Pay | 50% |
| **All Other Eligible Medical Expenses** | 85% | 50% |

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

IMPORTANT: CERTAIN SERVICES MAY REQUIRE AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

## BRONZE PLAN
## NO CHOICE OF PROVIDERS

The Plan Sponsor has contracted with organizations or "Networks" of health care providers. When obtaining health care services, a Covered Person must choose a provider who is participating in a Network. Non-Network providers are **not** covered, except in the limited circumstances described below.

The Plan Sponsor will automatically provide a Covered Person 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.

It is a Covered Person's responsibility, both personally and financially, to verify a provider's status (Network or Non-Network) for care at or from:

a provider he selected or was referred to at a specified location, because some providers participate at one location, but not at others;

a Physician who will be providing care; a

Hospital or other facility.

Although there may be circumstances when a Network provider cannot be used, Non-Network providers are only available and will be paid at the Non-Network benefit levels **EXCEPT** as follows:

Emergency Care for In-Area Residents - If a Covered Person has a Medical Emergency and must use the services of Non-Network providers, any such expenses will be paid at the Network benefit levels. This allowance will also apply when an in-area resident is traveling outside of the Network service area.

For those benefits where it does not specifically indicate a Network versus a Non-Network level of benefits, the Plan will pay benefits at the Non-Network levels applied to Usual and Customary allowances, except as follows:

Accident-Related Expenses - If a Covered Person requires care for an Accidental Injury, the first $500 of any such expenses will be paid at 100% of the Network Negotiated Rate. Allowable Charges must be incurred within 90 days of the accident. Please refer to the "Schedule of Medical Benefits" for additional information about this benefit.

Hearing-Related Services & Supplies - If a Covered Person requires a hearing evaluation or hearing aid, the Plan will pay for such expenses at 50% of the Network Negotiated Rate up to a maximum of $1,000 in any five (5) year period. Please refer to the "Schedule of Medical Benefits" for additional information about this benefit.

Home Health Care - Home Health Care benefits provide benefit payments at 100% of the Network Negotiated Rate, limited to a maximum of 100 visits per Calendar Year.

A Home Health Care Plan must be established in writing by the attending Physician of the Covered Person, and reviewed and approved through the **Utilization Management Program** procedures explained in this booklet. The attending Physician must certify that the Home Health Care Plan is for the same medical condition and that the proper treatment of the condition would require hospitalization in the absence of services provided under the Home Health Care Program.

The following items and services, and no others, are covered by this benefit:

- Part-time or intermittent skilled nursing services provided by a Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse;
- Part-time or intermittent Home Health Aid Services which provide supportive services in the home under the supervision of a Registered Nurse or a Physical, Speech, Occupational Therapist, or Audiologist;
- Physical, Speech, or Occupational Therapy;

- Medical supplies, drugs, and medicines prescribed by a Physician, and related pharmaceutical and laboratory services, to the extent they would have been covered under this Plan if the Covered individual had been in the hospital;
- Social work performed by a Licensed Clinical Social Worker;
- Nutrition services performed by a Licensed Nutritionist; special meals prescribed under the Home Health Care Plan.

Pre-Admission Testing - The Plan will pay for outpatient laboratory and X-ray tests prescribed by the attending doctor and required for inpatient admission and scheduled within thirty days of such admission at 70% of the Network Negotiated Rate.

Preventive Care - Except as exceeded by the Federally-Required Preventive Care benefits (see the **Appendix for Federally-Required Preventive Care Benefits**), the Plan will pay preventive care as follows:

well child care (up to age 19) - The Plan provides benefits for covered dependents to age nineteen (19) at 100% of the Network Negotiated Rate or 50% of the Non-Network Usual and Customary allowances for a routine or an annual physical examination, including X-rays or laboratory testing services ordered by the examining physician and for inoculations, vaccines and the well child exams required to give these vaccines (this includes sports physicals);

a routine physical exam (age 19 and above) - The Plan provides benefit payments at 100% of the Network Negotiated Rate or the Non-Network Usual and Customary allowances for a routine annual physical examination.

Second Surgical Opinion - The Plan will pay for the second surgical consultation at 100% of the Network Negotiated Rate. This benefit includes the examination and consultation only and must be performed within one month of the surgeon's recommendation for surgery. The specialist must not be a part of the medical group as the first opinion surgeon and cannot perform the prescribed surgery.

## BRONZE PLAN
## SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the schedule reflect the amounts the Plan pays of Allowable Charges after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the Negotiated Rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

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

NOTE: The Bronze Plan is available to Employee and Eligible Dependent Children to Age 26 (See “Eligibility” section and “Definitions” for further details.

| **LIFETIME / ANNUAL MAXIMUMS** | |
|---|---|
| Lifetime Maximum Benefit | Unlimited |
| Annual Maximum Benefit – see **NOTE** | Unlimited |

Lifetime dollar limits are not allowed for “essential health benefits.”

**NOTE: Where annual dollar limits may be applied in a schedule entry, below, the Plan Sponsor has determined that the benefit is not an essential health benefit.**

| **CALENDAR YEAR DEDUCTIBLES** | |
|---|---|
| Individual Deductible | $4,000 |
| Family Maximum Deductibles | $8,000 |

Individual Deductible - 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.

Family Maximum Deductible – The Family Deductibles must be satisfied during a Calendar Year before the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependent Children.

Eligible Expenses that are applied toward the Deductible in the last 3 months of a Calendar Year, will also be carried forward and applied to the Deductible for the following Calendar Year.

**NOTE: Where “†” appears in this schedule, it means that the Calendar Year Deductible does not apply.**

| **OUT-OF-POCKET MAXIMUMS** | |
|---|---|
| **Out-of-Pocket** Maximum | $5,000 |
| Family **Out-of-Pocket** Maximum | $10,000 |

Out-of-Pocket Maximum - Except as noted, once a Covered Person incurs more than the individual Out-Of-Pocket Maximum in any Calendar Year in Allowable Charges, the benefits payable by the Plan will increase to 100% for the balance of the Calendar Year. See **NOTE** below for those benefits that are not included when calculating Allowable Charges.

Family Out-of-Pocket Maximum - Except as noted, once a covered family (Employee and his covered Dependent Children) incurs more than $10,000 in any Calendar Year in Allowable Charges, the benefits payable by the Plan will increase to 100% for the balance of the Calendar Year. See **NOTE** below for those benefits that are not included when calculating Allowable Charges.

**NOTE: The Out-of-Pocket Maximums do not apply to or include:**

**expenses that are not covered by the Plan;**

**amounts in excess of the Non-Network UCR allowance for Non-Network services;**

**expenses that are paid by the Plan at 100%;**

**expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.**

IMPORTANT: CERTAIN SERVICES MAY REQUIRE AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

| **ELIGIBLE MEDICAL EXPENSES** | **You Pay** | **Plan Pays** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply.**<br>**Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service**. | | |
| **Accident-Related Expenses** First $500 per Accidental Injury | No charge<br>30% | Allowable Charges<br>70% |
| Allowable Charges must be incurred within 90 days of the Accidental Injury. | | |
| **Acupuncture** | 30% | 70% |
| Covered for pain management only. Must be prescribed by a Physician & services must be performed by a Board Certified Acupuncturist. | | |
| **Allergy Injections & Treatment**<br>Injections<br>Office Visit for Allergy Treatment | <br>30%<br>$60 Co-Pay† for first 3 visits then 30% | <br>70%<br>Remaining Allowable Charges |
| **Ambulance** | 30% | 70% |
| **Ambulatory Surgical Center** | 30% | 70% |
| Allowable Charges include the facility, surgeon, assistant surgeon, anesthesiologist, or certified nurse anesthetist. Requires prior authorization – see "Outpatient Surgery" in the **Utilization Management Program**. | | |
| **Anesthesia** | (see "Physician Services") | |
| **Birthing Center** | 30% | 70% |
| **Chiropractic Care**, per visit | 30% | 70% |
| Limited to 30 visits per Calendar Year. Children under age 18 must have a Physician referral. The "Network" for chiropractic care is ChiroMetrics, Inc. See the **Important Phone Numbers** section for contact information or to locate a Network provider. | | |
| **Contraceptives** | (see "Preventive Care Appendix") | Allowable Charges |
| **Diabetes-Related Services & Supplies**<br>Self-Management Training & Education, per visit<br>Diabetic Equipment & Supplies | <br>$60 Co-Pay† for first 3 visits then 30%<br>30% | <br>Remaining Allowable Charges<br>70% |
| Self-management training and education is limited to 4 day-care days per 24-month period. | | |
| **Diagnostic Testing, Outpatient**<br>Pre-Admission Testing<br>Outpatient (non-pre-admission) Services | <br>30%<br>30% | <br>70%<br>70% |
| **NOTE: Prior authorization is required for any single Outpatient diagnostic service procedure exceeding $350. A 50% benefit reduction will apply for failure to pre-certify.** | | |
| **Durable Medical Equipment (DME)** | 30% | 70% |
| Review by the **Utilization Management Program** is required for all DME over $500. | | |

| **ELIGIBLE MEDICAL EXPENSES** | **You Pay** | **Plan Pays** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply.**<br>**Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.** | | |
| **Hearing-Related Services & Supplies**<br>Hearing Screenings / Evaluations and Hearing Aids | 50% | 50% |
| Limited to a maximum of $1,000 In benefits per 5-year period (hearing evaluation / screening included within this maximum) and not to exceed 1 hearing aid per ear every 5 years.<br>A referral from an Ear Specialist (ENT, etc.) and a letter of Medical Necessity prior to treatment is required. Must be a non-conductive hearing loss with a PTA greater than or equal to 30db or a discrimination score of less than 76%. Conductive hearing loss at the discretion of an ENT only (based on Medical Necessity). | | |
| **Home Health Care** | 30% | 70% |
| Home Health Care includes home health visits and home visits for infusion therapy and injectables.<br>Home Health Care is limited to 100 visits per Calendar Year. Each visit by a nurse or by a therapist will count as 1 visit and each home health aide visit of 4 hours or less will count as 1 visit.<br>**NOTE: Requires prior authorization – see the Utilization Management Program**. | | |
| **Hospice Care** | 30% | 70% |
| Limited to a maximum benefit of $10,000 per Lifetime. | | |
| **Hospital Services** – see **NOTES** | | |
| Inpatient Care | 30% | 70% |
| Emergency Room Use (Network and Non-Network): | | |
| with subsequent admission | 30% | 70% |
| without subsequent admission | $100 Co-Pay, then 30% | 70% |
| Outpatient Surgery (e.g., surgery, anesthesia) | 30% | 70% |
| Other Outpatient Services & Supplies | 30% | 70% |
| Urgent Care Center Services & Supplies | $100 Co-Pay, then 30% | 70%, less a $100 Co-Pay |
| Allowable Charges for Inpatient room and board are limited: (1) at a Network Hospital, to the Network Negotiated Rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see **Definitions**) or the Usual and Customary charge for an Intensive Care Unit.<br>**NOTES: Inpatient admission requires prior authorization – see the Utilization Management Program. Outpatient surgery requires prior authorization by the Plan Administrator.**<br>**Emergency services are covered at the Network benefit levels, regardless of whether a Network provider is used.** | | |
| **Mental Health Care / Substance Use Disorder Care** | | |
| Inpatient Care, Residential & Partial Day Care | 30% | 70% |
| Emergency Room Care: | | |
| with subsequent admission | 30% | 70% |
| without subsequent admission | $100 Co-Pay, then 30% | 70%, |
| Other Outpatient Care | 30% | 70% |
| Outpatient Visits, per visit (visit only) | $60 Co-Pay† for first 3 visits then 30% | Remaining Allowable Charges for first 3 visits, then 70% |

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Mental health care and Substance Use Disorder Care is managed by **The Holman Group** – see **NOTE**

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. Also, "covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements).

Holman reimbursement for Out-of-Network Substance Use Disorder Care is the UCR determined using DRG's for higher levels of care and 125% of RVS for professionals, not to exceed provider's billed charges. Patient is responsible for difference between provider's billed charges and Holman reimbursement.

**NOTE: To obtain authorization for Mental Health and Substance Abuse benefits (Outpatient or Inpatient), an individual must contact The Holman Group at 1-800-321-2843.**

| **ELIGIBLE MEDICAL EXPENSES** | **Network** | **Non-Network** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply. Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.** | | |
| **Physician Services** | | |
| Office Visits, per visit (visit only) | $60 Co-Pay† for first 3 visits then 30% | Remaining Allowable Charges for first 3 visits, then 70% |
| Outpatient Surgery, Outpatient | 30% | 70% |
| Anesthesia | 30% | 70% |
| Other Services (Inpatient visits, surgeon, anesthesia, etc.), per visit | 30% | 70% |
| **Pre-Admission Testing** | (see "Diagnostic Lab & X-Ray, Outpatient" above) | |
| **Pregnancy Care** | (benefits are based on the types of services provided – see "Physician Services" and "Hospital Services" for example) | |
| Pregnancy coverage is limited to Employees and spouses. | | |
| **Prescription Drugs, Outpatient** | (see **Prescription Benefit Summary**) | |
| **Preventive Care** | | |
| Federally-Required Preventive Care Services | No charge | Allowable Charges |
| **Other Preventive Care Services** (to the extent they are not included in the Federally-Required Services): | | |
| Routine Physical Exams age 19 and older | No charge | Allowable Charges |
| Well Child Care up to age 19 (Includes sports physicals, visits, inoculations & vaccines) | No charge | Allowable Charges |

Federally-Required Services: (see **Appendix for Federally-Required Preventive Care Benefits**)

- services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force;
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- for infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- for women, additional preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

IMPORTANT: CERTAIN SERVICES MAY REQUIRE AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

| **ELIGIBLE MEDICAL EXPENSES** | **You Pay** | **Plan Pays** |
|---|---|---|
| **NOTES: Where "†" appears beside a benefit, it means that the Calendar Year Deductible does not apply.**<br>**Outpatient Surgery Benefit with Non-Network provider(s): Allowed amount will not exceed what would have been allowed through a Prudent Buyer Provider for the same service.** | | |
| **Second Surgical Opinion** | 30% | 70% |
| **Skilled Nursing Facility, Rehab. & Residential Center** | 30% | 70% |
| Allowable Charges for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 60 days per Calendar Year.<br><br>Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery.<br><br>**NOTE: Requires prior authorization – see the Utilization Management Program**. | | |
| **Sterilization Procedures** | (benefits are based on the types of services provided – see "Physician Services" and "Hospital Services" for example) | |
| **Substance Use Disorder Care** | (see "Mental Health Care / Substance Use Disorder Care" above) | |
| **Therapy, Outpatient** (occupational, physical, respiratory & speech) | 30% | 70% |
| Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery. | | |
| **Transplant-Related Expenses** | (benefits are based on the types of services provided – see "Physician Services" and "Hospital Services" for example) | |
| **NOTE: A proposed transplant requires prior authorization – see the Utilization Management Program.** | | |
| **Urgent Care Facility**, non-Hospital, per use | 30% | 70% |
| **All Other Eligible Medical Expenses** | 30% | 70% |

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

IMPORTANT: CERTAIN SERVICES MAY REQUIRE AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

# ELIGIBLE MEDICAL EXPENSES

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

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Negotiated Fee or the Usual, 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 delivery is made; or

the actual date a service is rendered.

**Acupuncture** - Acupuncture therapy when provided by a Physician or Board Certified and licensed acupuncturist, when used as a form of pain management only.

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

**Allergy Injections & Treatment** - The services and supplies provided by a Physician or licensed technician or clinic for the provision of a substance to induce a specific immune response or desensitization for allergic disorders.

**Ambulance** - Professional ground or air ambulance service when Medically Necessary and used to transport the Covered Person from the place where he is injured or stricken by a Sickness to or from the nearest Hospital where treatment can be given, from the Hospital to the Covered Person's home or to a Skilled Nursing Facility when there is documentation that the patient required ambulance transportation.

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

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

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

**Blood** - Blood, blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

**Cardiac Rehabilitation** - A Physician-supervised and monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease and provided in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

**NOTE: Maintenance care will <u>not</u> be covered.**

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

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

**Chiropractic Care** - Diagnostic evaluations and musculoskeletal manipulation and modalities (hot & cold packs, etc.) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

**Contraceptives -** Contraceptive supplies, and related Physician or professional services necessary for their administration. Such contraceptives include but are not limited to:

a. Injectable drugs and implants for birth control, administered in a Physician's office;
b. Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a Physician;
c. Professional services of a Physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If a Plan Participant's Physician determines that none of the above contraceptive methods is appropriate for the individual based on her medical or personal history, the Plan will provide coverage for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and is prescribed by the Physician.

IUD and Depo-Provera from a non-Network Provider:
If an IUD is elected, such contraceptive must be in lieu of all other forms of birth control for at least five (5) years. Removal costs will be covered only after a minimum of five (5) years from date of insertion.

Services and supplies in conjunction with Depo-Provera (an injectable form of birth control) with a three-month duration.

Any contraceptive that can be obtained through the Plan's prescription drug program (see "Prescription Drugs, Outpatient" in the Medical Benefit Summary), must be obtained through that program.

**NOTE: Any contraceptive that can be obtained through the prescription drug program (see the Prescription Benefit Summary), must be obtained through that program.**

**Diabetes-Related Services & Supplies** - Outpatient self-management training, education and medical nutrition therapy when provided under the direction of or prescribed by a Physician. Such training and education must be provided by appropriately licensed or registered health care professionals (such as a registered nurse, registered pharmacist or registered dietitian) and must be designed to enable a Covered Person to properly use the diabetic equipment and supplies (as listed below) for daily self-management of diabetes.

The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes:

blood glucose monitors;

insulin pumps and all related necessary supplies;

podiatric (foot) devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes.

**NOTE: Diabetic testing supplies that are available through the Plan's prescription drug program must be obtained through that program – see the Prescription Benefit Summary.**

**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** - Dialysis services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

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

"Durable medical equipment" includes such items as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen, peak flow monitors for self-management of asthma, apnea monitors (C-Pap, Bi-Pap) including equipment for management of newborn apnea, and dialysis equipment, etc., that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, (4) are not for exercise, (5) are not for environmental control, and (6) are appropriate for use in the home.

**NOTE: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.**

**Hearing-Related Services & Supplies** - see the **Medical Benefit Summary**

**Home Health Care** - The following home-care services:

Home Health Care - Home health care services that are ordered by a Physician or clinic, consistent with a Covered Person's Sickness or Accidental Injury and provided under a home health care plan. The home health care plan must: (1) provide for continued care and treatment following a patient's discharge from a Hospital, and (2) be for the same or related condition requiring hospitalization or be an alternative to staying in the Hospital. The patient's condition and care must require the specialized training of a registered nurse (RN), licensed vocational nurse (LVN), licensed practical nurse (LPN), home health aide, or a physical, occupational or speech therapist. Coverage does not include services that are primarily for housekeeping, personal hygiene or custodial care.

Home Infusion Therapy / Home Injectables - Administration, by an appropriate Covered Provider, of prescription drugs by injection into a vein, a muscle, the skin or the spinal canal. It also includes drugs administered by aerosol into the lungs or by a feeding tube.

**Hospice Care** - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care, and bereavement counseling services provided to Covered Persons who are members of the patient's family. Allowable Charges include Hospice program charges for:

Inpatient services and supplies;

bereavement counseling for family members – up to 6 months following the patient's death and up to a maximum of 6 visits;

private-duty nursing services; and

Outpatient services and home health care services (as described above) provided through a licensed Hospice.

**NOTE: Eligible Hospice care expenses will not include:**

pastoral, financial or legal counseling;

funeral arrangements;

homemaker, caretaker or transportation services for the family; housecleaning or

house maintenance expenses.

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

Prior authorization is required for Outpatient surgery that is to be performed in a Hospital setting. Such authorization must be obtained from the Plan Administrator.

**Injectables** - Injectables that are not available through the prescription drug program and professional services for their administration if they cannot be self-administered. See "Home Health Care" for in-home coverage information.

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

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

**Mental Health Care / Substance Use Disorder Care** - The following services and supplies for treatment of mental health conditions and substance use disorders:

for mental health care - Inpatient, residential and partial day facility care, and Outpatient treatment by a Physician, Psychiatrist, Psychologist, Marriage Family Therapist, or Licensed Clinical Social Worker, and

for substance use disorder care - Inpatient, acute detoxification, residential, partial day care and Outpatient

treatment.

Mental Health Condition: For Plan purposes, a "mental health condition" is a nervous condition, psychosis or neurosis diagnosed as falling within categories 290 through 302 and 305 through 319 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare, as amended.

Substance Use Disorder: For Plan purposes, a "substance use disorder" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Also see section entitled **Holman Family Counseling, Inc.**

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

**Newborn Care** - Medically Necessary services and supplies, as listed herein, for a covered newborn who is sick or injured. Also see "Pregnancy Care" for well newborn expenses.

**Occupational Therapy** - see "Therapy, Outpatient"

**Orthotics** - The following orthotic devices:

orthopedic (non-dental) braces and orthopedic shoes when an integral part of a brace;

orthotics or orthopedic appliances when used to treat a condition requiring more than a supportive device of the foot or not primarily used for the support or comfort of the foot, including casts and splints; and

other orthotics or orthoses used to support the knee, back, hip and upper extremity that are prescribed by a Physician and custom made.

**NOTE: Trusses, corsets and other support items are not covered.**

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

**Physical Therapy** - see "Therapy, Outpatient"

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

**NOTE: Physician charges for technical medical assistance or standby services are not covered.**

**PKU Special Food Products & Enteral Formulas** - Food products that are Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function and that are:

prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU);

consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experienced in the treatment and care of phenylketonuria.

**NOTE: This does not include food products that are naturally low in protein, but may include a food product that is specifically formulated to have less than one (1) gram of protein per serving and used in place of normal food products, such as grocery store foods used by the general population.**

**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;

home uterine monitoring, including all monitors and Terbutaline;

a non-elective abortion procedure and any complications arising out of an abortion;

routine well-newborn Hospital services and supplies and a Physician's initial exam when provided during the mother's confinement for delivery and provided the child is enrolled for Plan coverage within thirty (30) days of birth.

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

"Complications of pregnancy" will be covered as any other Sickness and will be covered with regard to an Employee, spouse or a Dependent child. "Complications of pregnancy" include conditions that require Hospital confinement (when the pregnancy is not terminated) and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as:

acute nephritis, nephrosis, cardiac decompensation, pre-eclampsia, missed abortion and similar medical and surgical conditions of comparable severity, but excluding false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness and similar conditions that, although associated with the management of a difficult pregnancy, are not medically classified as distinct complications of pregnancy;

a nonelective cesarean section, an ectopic pregnancy that is terminated, or spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; and

pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of pregnancy).

**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) any charges or services related to surrogate pregnancies.**

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

Coverage for other Outpatient drugs (i.e., pharmacy purchases) is provided through a separate program. See the **Medical Benefit Summary** for additional information.

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

**NOTE: Immunizations, exams or reports required for obtaining or continuing employment, insurance purposes, government licensing, or travel are not covered.**

**Prosthetics** - An initial artificial arm, shoulder, leg, hip, knee or eye. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses and the first bra made solely for use with the prosthesis.

Repair or replacement of a prosthetic when required due to wear or damage if Medically Necessary and ordered by a Physician.

**NOTE: Any type of communicator, voice enhancement, voice prosthesis or any other language assistive device is not covered.**

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

**Respiratory Therapy** - see "Therapy, Outpatient"

**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 Plan Participant is participating in a phase I, II, III or IV Approved Clinical Trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:

The clinical trial is approved by:
The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
- The National Institute of Health;
- The U.S. Food and Drug Administration;
- The U.S. Department of Defense;
- The U.S. Department of Veterans Affairs; or

- An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
- 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:
- 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;
- 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;
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- A cost associated with managing an Approved Clinical Trial;
- The cost of a health care service that is specifically excluded by the Plan; or
- 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 Approve Clinical Trial.

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

The opinion must be secured from a specialist in the field for which the patient is considering surgery and must be obtained within one (1) month of the surgeon's recommendation for surgery. The second opinion specialist must not be a part of the same medical group as the first opinion surgeon and cannot perform the prescribed surgery.

**Skilled Nursing Facility** - Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and:

the patient is confined as a bed patient in the facility;

the attending physician certifies that the confinement is needed for further care of the condition that caused the hospital confinement; and

the attending physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the skilled nursing facility.

**Sleep Disorders** - Sleep studies and related services and supplies. See "Durable Medical Equipment" for sleep apnea equipment.

**Speech Therapy** - see "Therapy, Outpatient"

**Substance Abuse Care** - see "Mental Health Care / Substance Use Disorder Care" above

**Temporomandibular Joint Dysfunction (TMJ)** - Medically Necessary services and supplies for the treatment of TMJ. A Second Surgical Opinion is mandatory for these services.

Purchase or rental of TMJ appliances is subject to prior authorization by the Plan Administrator.

**Therapy, Outpatient** - The following therapy services provided on an Outpatient basis. Proof of Medical Necessity will be required following thirty (30) days of therapy without surgery and following ninety (90) days with surgery:

occupational therapy by a registered/certified occupational therapist when ordered by a Physician or clinic to correct physical impairment caused by Sickness or Accidental Injury;

physical therapy by a registered physical therapist when ordered by a Physician or clinic for treatment of impaired body function due to Sickness or Accidental Injury;

respiratory therapy by a licensed respiratory or inhalation therapist when ordered by a Physician or clinic for treatment of impaired body function due to Sickness or Accidental Injury;

speech therapy by a certified speech therapist when ordered by a Physician to treat loss of speech following an illness or injury only.

For therapy services provided in the patient's home, see "Home Health Care."

**Transplant-Related Expenses** (Human Tissue) - Subject to the following, a non-experimental human organ/tissue transplant when a Covered Person is the transplant recipient or a transplant donor and Case Management is performed (see “Case Management Services” in the **Utilization Management Program** section).

If the organ or tissue recipient is a Covered Person, then expenses of an organ donor who is not a Covered Person will be treated as expenses of the covered recipient. However, the donor’s benefits will be reduced by any benefits paid or payable by the donor’s own coverage.

Bone, skin or cornea transplants are eligible for benefits when both of the following criteria are met:

the services are Medically Necessary and appropriate; and

the Physicians on the surgical team and the facility in which the transplant is to take place are approved (see the **Utilization Management Program**).

The following procedures must meet the above criteria and must be performed at a Center of Excellence:

artery or vein
bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures
heart
heart/lung
heart valve replacements
joint replacements
kidney/pancreas
liver
lung

In addition to Eligible Medical Expenses as listed herein, eligible transplant-related expenses will include Allowable Charges of an organ donor to the extent that benefits to the donor are not provided under any other form of coverage. In no case will any payment of a "personal service" fee be made to the donor and benefits paid will be applied to reduce benefit maximums as though all expenses were incurred by the Covered Person recipient.

**Urgent Care Facility - see Definitions**

# MEDICAL LIMITATIONS AND EXCLUSIONS

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

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

**NOTE: Complications arising out of an abortion are covered. See "Pregnancy Care" in the Eligible Medical Expenses section.**

**Accidents While Intoxicated** - Injuries received while the Covered Person is under the influence of any drug (whether or not prescribed) or alcoholic beverage, or which the Covered Person sustained as a result of the Covered Person's voluntary consumption of any drug (whether or not prescribed) or alcoholic beverage.

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

**Behavioral or Learning Disorders** - Treatment of social maladjustment, behavioral or antisocial problems that are not specifically resulting from a mental health condition, including delayed language development, mental retardation or dyslexia, syndromes associated with disorders attributed to perceptual and conceptual dysfunction (ADD and/or ADHD), and associated behavior problems or developmental articulation or language disorders.

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

**Complications of Non-Covered Treatments** - Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

**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 or repair necessitated by an Accidental Injury or Sickness;

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 and will include the first two (2) bras made solely for use with the prosthesis;

surgery to the improve the function of a body part malformed as a result of a severe birth defect (such as harelip or webbed fingers or toes) or to improve the function of a body part (other than the teeth or structures supporting the teeth) that is malformed.

**Counseling Services** - Services for or in connection with pastoral or financial counseling.

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

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

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

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

surgery for tumors of the gums;

repair of the jaw, mouth or sound natural teeth damaged in an Accidental Injury but limited to services received within six (6) months following the injury; or

Hospital room and board and necessary ancillary Hospital services for dental or oral surgery when Inpatient confinement is certified in writing by a Physician as Medically Necessary to safeguard the life of the patient.

**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 (except for the treatment of heavy metal poisoning), orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

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

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness (e.g., nutritional counseling and/or diet management), 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.

**Family Planning / Contraceptive Management** – Except as required by federal law, non-Network charges for Diaphragms, Physician visits for diaphragm fittings, and any other birth control products except Depo-Provera and IUDs.

Any charges related to services for voluntary sterilization reversal, or for fertility or infertility treatment.

**Financial Counseling** - Services related to consultations concerning personal and family finances.

**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.

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

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

**Growth Hormones**

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

**Hearing Exams & Hearing Aids** - Hearing examinations or hearing aids, except as expressly included – see "Hearing-Related Services & Supplies" in the **Medical Benefit Summary**.

**Holistic, Homeopathic or Naturopathic Medicine** - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment. Charges for services incidental to acupuncture unless Medically Necessary and prescribed by a Physician, subject to medical review and covered for pain management only when performed by a Board Certified Acupuncturist.

**Hypnotherapy** - Treatment by hypnotism.

**Impregnation** - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, or services from or related to Vitro (test tube baby) expenses other than maternity delivery, whether or not any such procedure is successful.

**Infertility Services -** see "Family Planning / Contraceptive Management" above

**Maintenance Care** - see “Custodial & Maintenance Care”

**Marriage & Family Counseling** - Counseling for marital or family problems when there is no diagnosed mental health condition.

**Massage Therapy -** Services that include the rubbing or kneading of parts of the body to aid circulation, relax the muscles and/or to relieve pain.

**Maternity Care for a Dependent Child** - see “Pregnancy Care” in the list of **Eligible Medical Expenses**

**Nicotine or Caffeine Addiction** - Physician visits, withdrawal programs, support groups, facility services, drugs or supplies for caffeine or nicotine addiction.

**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 as may be included in the prescription coverages of the Plan.

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

**Not Medically Necessary / Not Physician Prescribed / Not Generally Accepted** - 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.

Treatment that is not generally accepted practice in the United States.

**Nursing Services, Private Duty** - Private-duty nursing services, except as provided under “Home Health Care” and “Hospice Care.”

Nursing services furnished when a Covered Person is in a health care facility when such services could have been safely and adequately furnished by the general nursing staff if the facility was fully staffed.

**Orthognathic Surgery** - Surgery to correct a receding or protruding jaw or any other services or supplies primarily for treatment of and/or in connection with orthognathic, prognathic and/or maxillofacial surgery (except in the treatment of TMJ).

**Orthopedic Shoes and Related Devises** - Expenses for orthopedic shoes and other supportive devices for the feet, other than such items covered under the Plan such as braces, crutches, casts, or splints.

**Pain Management** - Confinement in a Hospital or pain management center to treat or cure chronic pain, except when Medically Necessary.

**Personal Comfort or Convenience Items** - Services or supplies that are primarily and customarily used for non-medical 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.

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

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

Penile implants, unless required as a result of Accidental Injury or an organic disorder.

**Speech Therapy** - Services or supplies for speech therapy except as expressly covered – see "Therapy, Outpatient" in the **Eligible Medical Expenses** section.

**Stress Management Programs** - Services related to the management or relief of stress.

**Vaccinations** - Immunizations or vaccinations other than: (1) those included within the "Preventive Care" coverages (see the **Medical Benefit Summary** and **Appendix**), and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

**Vision Care** - Eye examinations for the purpose of prescribing corrective lenses, except as expressly included – see "Preventive Care" in the **Medical Benefit Summary**.

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

Orthoptics or vision therapy or other eye exercises, except when performed in lieu of surgery to correct an eye muscle disorder.

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: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery.**

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

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

**Weight Control** - No benefits are provided for:

services, supplies or programs for eating disorders, obesity, weight reduction or appetite or dietary control; or

any charges relating to gastric bypass surgery or reversal, gastric stapling or reversal, or other similar gastric surgical procedures, or complications arising there from.

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

# PRESCRIPTION BENEFIT SUMMARY

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and prescription drug vendor(s). If there are any conflicts between the prescription information in this document and the terms of such agreement(s), the agreement(s) will prevail.

## OUTPATIENT DRUG CARD – CAREMARK
## GOLD PLAN

| | |
|---|---|
| **Out-of-Pocket Maximum** | $2,250 per Individual |
| | $4,500 per Family |

| **Pharmacy Benefit** | **Retail** | **Mail Order** |
|---|---|---|
| Generic Drug | $5 | $10 |
| Preferred Drug | $30 | $60 |
| Non-Preferred Drug | $50 | $70 |
| Non-Formulary Drug | $50 | $100 |
| Specialty/Other | $100 | $100 |

## BRONZE PLAN

| | |
|---|---|
| **Rx Deductible** | $1,000 per Individual<br>$2,000 per Family |
| **Out-of-Pocket Maximum** | $1,600 per Individual |
| | $3,200 per Family |

| **Pharmacy Benefit** | **Retail** | **Mail Order** |
|---|---|---|
| Generic Drug | $9 | $18 |
| Preferred Drug | $35 | $70 |
| Non-Preferred Drug | $55 | $90 |
| Non-Formulary Drug | $100 | $100 |
| Specialty/Other | $100 | $100 |

To use the retail feature, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 34-day supply for the Co-Pays shown. To obtain information about the Formulary, contact the prescription program provider.

**A mail-order option is included for maintenance (longer-term) drugs. Mail-order drugs are available in up to a 90-day supply for 1 Co-Pay. The Plan requires that maintenance medications be obtained through the mail-order option after 2 fills at a pharmacy.**

Generic drugs are automatically dispensed if a generic form is available. If a brand-name drug is purchased when a generic drug is available, the Covered Person will be responsible for paying the brand-name Co-Pay and the difference in cost between the generic and brand-name drug.

**This is only a summary of the prescription drug coverages offered by the plan. The actual controlling provisions and lists of covered and excluded drugs, etc., must be obtained directly from the plan sponsor or the prescription program provider.**

## COVERED DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs and compounded drugs that are prescribed by a Physician and that require a prescription either by federal or state law) and certain non-prescription items.

The following is an abbreviated summary list of prescription and non-prescription drugs and supplies that are covered by this Plan.

**Bee Sting Kits**

**Contraceptives, Oral** - Legend oral contraceptives.

**Diabetic Supplies** - Diagnostic supplies including, but not limited to: syringes (subject to home delivery after 2 retail fills), needles, devices, pump supplies, swabs, test strips (glucose or ketone), lancets and lancet devices.

**Injectables & Supplies** - Injectable insulin and Imitrex, and disposable needles & syringes for their administration.

**Require Written Prescription** - Any drug which under applicable state law may only be dispensed upon written prescription of a physician or other lawful provider.

## EXPENSES NOT COVERED

Prescription drug coverage will not include:

**Anorexiants** - Any drug or supplement intended for the use of weight loss or weight management.

**Contraceptives** - Any injectable, implant, intrauterine device (IUD), diaphragm, kit & cervical cap intended for the use of contraceptive management.

**Cosmetic Drugs** - Drugs with cosmetic indications, anti-wrinkle creams, except for Tretinoin drugs (i.e., Retin-A) when used for the treatment of acne vulgaris.

**Devices, Appliances, and Medical Supplies** - Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

**Dietary Supplements** - Any drug or supplement intended for the use of dietary supplement, such as vitamins, minerals, or liquid diet replacements, regardless if they are prescribed by a physician, for eligible persons ages 19 and older.

**Erectile Dysfunction** - Any drug used for the treatment of erectile dysfunction (i.e., Cialis, Levitra & Viagra).

**Excess Refills** - Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.

**Experimental & Non-FDA Approved Drugs** - Experimental drugs and medicines, even though a charge is made to the Covered Person. Drugs not approved by the Food and Drug Administration.

**Fertility Drugs** - Any drug used for the treatment of infertility.

**Growth Hormones**

**Hair Loss / Hair Removal Drugs** - Any drug used for the treatment of hair loss (i.e., Minoxidil or “Rogaine”) or hair removal.

**Homeopathic Drugs** - Legend or non-Legend homeopathic drugs.

**Immunizations Agents** - Serums, toxoids, vaccines.

**Insulin / Diabetic Items** - Diabetic supplies, except as included – see “Injectables & Supplies.”

**Investigational Drugs** - A drug or medicine labeled: “Caution – limited by federal law to investigational use.”

**No Charge** - A prescribed drug that may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

**Non-Home Use** - Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

**Non-Prescription Drugs** - A drug or medicine that can legally be bought without a written prescription. This does not apply to insulin.

**OTC - Equivalents** – Drugs having over-the-counter equivalents.

**Weight Management Drugs -** Drugs intended for the use of weight loss or weight management.

**Work Related Drugs -** Charges for prescriptions which are covered by Workers Compensation laws and other county, state or federal programs.

**DISCLAIMER: THIS IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED BY THE PLAN. THE ACTUAL CONTROLLING PROVISIONS AND LISTS OF COVERED AND EXCLUDED DRUGS, ETC., MUST BE OBTAINED DIRECTLY FROM THE PLAN SPONSOR OR THE PRESCRIPTION PROGRAM PROVIDER.**

# DENTAL BENEFIT SUMMARY

## DENTAL PRE-TREATMENT REVIEW

If charges for treatment are expected to exceed $300.00, it is strongly recommended that the dentist submit a pre-treatment estimate that describes the treatment and cost, along with X-rays, to the Contract Administrator in advance of treatment. In lieu of the statement, the dentist may call the Claims Department. The Contract Administrator will then determine which parts of the treatment are covered dental expenses, and estimate how much the Plan will pay for treatment. If more than one treatment is available, the Plan will pay for the least expensive method regardless of the method used.

## SCHEDULE OF DENTAL BENEFITS

Dental benefits are subject to all of the provisions, exclusions & limitations explained in detail in these dental benefit sections. The following represents only a summary of the available benefits. Please refer to the other sections within this Plan Document for additional information on Plan benefits.

Actual payment for Allowable Charges listed may be limited by Usual and Customary fees, Negotiated Contract Rates, Deductible, Co-Pays, Percentage Payable and/or benefit maximums as indicated below. Covered procedures not included on this listing will be paid at comparable values as determined by the Plan. Allowable Charges is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury.

| **PLAN MAXIMUMS** | |
|---|---|
| Calendar Year Maximum Benefit (non-ortho) | $1,250 |
| Orthodontia Lifetime Maximum Benefit | $1,000 |
| Plan benefits for each Covered Person will not exceed the maximums shown above. | |
| Orthodontia benefits do not apply to the Calendar Year Maximum Benefit. The Orthodontia Lifetime Maximum Benefit applies to all periods a person is covered hereunder. | |
| **ELIGIBLE DENTAL EXPENSES** | **Plan Pays** |
| **Basic Services** | |
| Year 1 of Coverage | 70% of Allowable Charges |
| Year 2 of Coverage | 80% of Allowable Charges |
| Year 3 of Coverage | 90% Of Allowable Charges |
| Year 4 or more of Coverage | 100% of Allowable Charges |
| The percentage that the Plan will pay increases each Calendar Year of the Covered Person's eligibility by 10% provided the subscriber has utilized the Plan during the preceding Calendar Year. If during a Calendar Year of eligibility, the subscriber does not utilize the Plan, the portion that the Plan will pay for services provided during the next succeeding Calendar Year shall remain the same. | |
| **Major Services** | 50% of Allowable Charges |
| Covered charges include construction, repair and maintenance of bridgework and dentures, and installation of bridgework, and dentures. | |
| **Orthodontia** | 50% of Allowable Charges |

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

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## DETERMINATION OF PAID DENTAL PLAN BENEFITS

Subject to the exclusions, conditions and limitations stated in this Plan Document, the Plan will pay benefits to, or on behalf of, a Participant for covered dental expenses up to the maximums specified within this Plan Document. The Plan will pay benefits for the Usual and Customary charges for services and supplies, which are ordered by a Dentist. Services and supplies must be furnished by an eligible Provider and be Dentally Necessary. Allowable Charges is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury. All payments made under this Plan for allowable charges will be limited to Usual and Customary charges and/or Negotiated Fee Rate.

The fact that a procedure or level of care is prescribed by a Dentist does not mean that it is Allowable Charges under the Plan and shall not bind Central Unified School District in determining the liability under the Plan. Services which are not reasonable and necessary shall include, but are not limited to:

procedures that are experimental, of unproven value or of questionable current usefulness;

procedures that tend to be redundant when performed in combination with other procedures;

procedures that are unlikely to provide a Dentist with additional information when they are used repeatedly;

procedures that can be performed with equal efficiency at a lower level of care.

Approval of a claim is subject to the determination of the Dental Necessity of provided services. Dental Necessity is a broadly accepted professional term meaning services were essential to treatment of the Illness or Injury. Treatment determined to be Dentally Necessary will follow guidelines where such treatment:

is consistent with symptoms or diagnosis and treatment of the condition, disease, ailment or Injury

is appropriate with regard to standards of good dental practice

is not primarily for the conveniences of the patient or other Provider

is the most appropriate supply or level of services that can safely be provided to the patient. When applied to an inpatient, it means the patient's symptoms or condition require services or supplies which cannot be safely provided to the patient as an outpatient.

Please refer to the definitions section of this Plan Document for a complete definition of Dental Necessity or Dentally Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with this Plan Document. Benefits will be paid for the reimbursement of Dental Expense incurred by the Participant if all provisions mentioned in this Plan Document are satisfied.

The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Dentally Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

Benefits are determined by taking the amount of Allowable Charges for all Dentally Necessary services, subtracting any applicable Deductible, and paying the remaining at the Plan's Percentage Payable up to the Plan Maximum. Allowable Charges will be no more than the Usual and Customary charges as determined by the Plan or the Negotiated Fee Rate if services are performed by a Participating Dentist. Allowable Charges is subject to the exclusions, conditions and limitations stated within this Plan Document. Services and supplies must be ordered by a Provider and be furnished by an eligible Provider and be Dentally Necessary.

# ELIGIBLE DENTAL EXPENSES

**Percentage Payable**: Percentage Payable is the percentage applied against the Allowable Charges to obtain the amount the Plan will pay for each covered service. Allowable Charges is the Usual, Customary and Reasonable charges for the geographic area where services are performed or the Negotiated Fee Rate.

**Basic Services**: Basic services are payable at 70% to 100% of Allowable Charges depending upon a Covered Person's length of eligibility under the Plan and whether or not the Employee's family unit has routinely utilized dental services each Calendar Year.

The Plan will pay 70% of the Allowable Charges for Dentally Necessary services to any Eligible Person during the first Calendar Year of his/her eligibility. The Percentage Payable will increase to 80%, 90% and 100% respectively, during the second, third and subsequent Calendar Years of a Participant's eligibility, provided he/she has utilized the Plan during the preceding Calendar Year.

If during a Calendar Year of eligibility, the family unit does not utilize the dental benefits, the portion that the Plan will pay for services provided during the next succeeding Calendar Year will remain the same.

Basic services include but are not limited to:

Diagnostic Services:

Oral Exams – office visit during regular office hours for oral exam, limited to two (2) in any Calendar Year

X-rays to include: a) bitewing films, limited to two (2) sets in any Calendar Year for individuals to age 19 and once for individuals age 19 and over, b) complete mouth survey or panoramic x-rays, limited to one (1) time in any period of two (2) years, and c) single films or periapical films

Emergency palliative treatment and other non-routine, unscheduled visits

Biopsy and examination of oral tissue

Diagnostic casts and study models

Preventive Services:

Prophylaxis including periodontal prophylaxis, scaling and polishing, limited to two (2) cleanings or prophylaxis per Calendar Year

Fluoride treatment to prevent tooth decay is limited to Dependent children up to age nineteen (19)

Sealants for children up to age nineteen (19)

Space maintainers

Oral Surgery:

Simple extractions

Surgical extractions including erupted, soft tissue impaction, partial bony impaction & complete bony impaction

Root removal – exposed roots

Root recovery – surgical removal of residual root

Removal of a dentigerous cyst

Incision and drainage of an abscess

Surgical exposure of impacted tooth to aid eruption

Removal of exostosis

Frenulectomy

Alveoplasty

Excision of hyperplastic tissue or redundant tissue

Oral antral fistula closure

Transseptal fiberotomy

Vestibuloplasty

Crown exposure for orthodontia

Excision of pericoronal gingiva, per tooth

Reimplantation of tooth

Closure of salivary fistula

Dilation of salivary duct

Suture of soft tissue injury

Sialolithotomy for removal of salivary calculus

Sequestrectomy for osteomyelitis or bone abscess

Maxillary sinusotomy for removal of tooth fragment or foreign body

Removal of tumors / cysts

Restorative Services:

Amalgam restorations, primary teeth

Amalgam restorations, permanent teeth

Anesthesia – in conjunction with surgical services

Silicate restoration

Acrylic, plastic, composite, synthetic porcelain, resin restoration

Posts and pins, independent of any other procedure

Stainless steel crowns – when tooth cannot be restored with a filling material

Temporary crown or repair for a fractured tooth

Sedative fillings

Consultations, Hospital calls

Crown repair

Therapeutic drug injection

Crowns and other porcelain or cast restorations when carious lesions or traumatic injury have produced extensive breakdown of the tooth, including repair and recementation

Restorative Inlays and onlays, including recementation

Crown buildups

Labial veneers

Endodontics:

Pulp capping, direct

Remineralization, as a separate procedure

Vital Pulpotomy

Apexification

Root canal therapy on non-vital (nerve dead) teeth

Apicoectomy, as a separate procedure or in conjunction with other endodontic services

Periodontics:

Gingivectomy or gingivoplasty

Sub-gingival curettage and root planing

Osseous surgery, including flap entry and closure Muco-

gingival surgery

Occlusal adjustment

**Major Services:** Major services are payable at 50% of Allowable Charges. Allowable Charges include but are not limited to:

Bridgework and Dentures:

Services needed to replace one (1) or more natural teeth that are lost while the Participant is covered under this Plan

Initial installation of fixed bridgework

Initial installation of a partial removable denture, including adjustments within the six (6) month period following installation

Initial installation of a full removable denture, including adjustments within the six (6) month period following installation

Replacements & Adjustments, etc:

Replacement of an existing removable denture or fixed bridgework if:

It is needed because of the loss of one (1) or more natural teeth after the existing denture or bridgework was installed, or

It is needed because the existing denture or bridgework can no longer be used and was installed at least five (5) years before its replacement.

Replacement of an existing immediate full denture by a new permanent full denture when:

the existing denture cannot be made serviceable, and

the permanent denture is installed within twelve (12) months after the existing denture was installed.

Recementation or repair of bridges

Adjustment to denture more than six (6) months after installation

Tissue conditioning

Denture relining

**Orthodontic Services:** Services are payable at 50% of Allowable Charges up to a Lifetime maximum of $1,000 for the treatment of malalignment of teeth/jaws.

**Plan Maximum**: The Plan Maximum benefit for each Covered Person is $ 1,250 per Calendar for basic and major services. The amount of Allowable Charges is the aggregate or total of benefits payable during any one Calendar Year.

The Lifetime Maximum Benefit is $1,000 for Orthodontic Services.

**Incurred Expense:** a charge is considered incurred:

in the case of dentures or partial dentures, the date when the appliance is placed;

in the case of fixed bridges, inlays, onlays, or crown work, the date when the appliance is placed;

in the case of root canal therapy, the date when the root canal is completed;

in the case of periodontal surgery, the date when the surgery is performed;

in the case of any other work, the date when the work is performed.

# DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Treatment rendered solely for Cosmetic purposes.

Any service, including any type of prosthesis, started prior to the individual becoming covered with this Employer.

Treatment by other than a Licensed Dentist, except charges for dental prophylaxis performed by a dental hygienist under the supervision and direction of a dentist.

Replacement of a bridge or denture within 5 years of the original date of installation for any reason, including loss or theft, unless:

necessary because of placement of a new opposing appliance;

due to extraction of additional natural teeth; or,

the appliance, while in the patient's mouth was damaged beyond repair by an Accidental injury that occurred while covered by the Plan.

Replacement of any bridge or denture, which is satisfactory or can be made satisfactory.

More than two (2) cleanings and oral examinations in any Calendar Year. More than two (2) sets of bitewing x-rays in any Calendar Year for individuals to 19 years of age, and more than one (1) set in any Calendar Year for those over 19 years of age. Full mouth set of x-rays more than once in any two (2) year period. Fluoride treatments and Sealants to age 19.

Services, supplies and appliances, which are more elaborate than those customarily employed. Recognizing that many dental problems can be solved in more than one way, the Plan will pay the amount equal to the service or procedure that generally is an acceptable treatment, which in its sole judgment, will provide adequate dental care at the lowest cost to the Participant. In determining its liability, the Plan will be guided by nationally established standards of the dental profession. If an individual pursues the most expensive course of treatment, this Plan may pay the equivalent of the less expensive treatment that adequately restores the mouth to normal form and function. The payment may be applied to a more expensive course of treatment.

Experimental procedures, training in plaque control or oral hygiene, or dietary instruction.

Charges for a patient's failure to keep a scheduled appointment or for completion of claim forms.

Charges for any services for which the covered person is not legally required to pay.

Charges for dental services or supplies, which are covered under any other group plan, covered or sponsored by the Employer.

Any loss sustained while doing any act or thing pertaining to any occupation or employment for pay or profit.

Any loss for which the covered person is entitled to benefits under Workers' Compensation or any similar law.

Any loss sustained while on active duty in the armed forces.

Services not reasonably necessary, or not customarily performed.

Loss caused by or contributed to by war or an act of war, whether declared or not.

Charges for dental services rendered by a member of the covered person's Immediate Family.

Charges for relining or rebasing a denture/partial within the first six (6) months after the appliance was placed.

Charges for additional treatment necessitated by lack of patient cooperation with the dentist, or non-compliance with prescribed dental care, which results in additional liability.

Adjustment of prosthetic appliances within six (6) months of initial installation and not included in the cost of such appliance.

Pontics for reasons other than replacement of missing teeth.

Charges for characterizations of crowns, dentures, or bridgework.

Charges for facings, veneers or similar material placed on molar crown or pontics.

Charges for take home items such as fluoride rinse, tooth brushes and floss.

Charges for any temporary procedure or appliance.

Replacement of lost or stolen prosthesis.

Hospital charges and prescription drug charges.

Dental accident benefits provided more than 180 days following the date of the Accidental Injury, and any services for conditions caused by an Accidental Injury occurring before the eligibility date.

Services and supplies received after the termination of coverage under this Plan except for prosthetic devices which are ordered while covered and delivered within thirty (30) days after termination.

Charges or services involving dental implants.

## DENTAL TIPS

A CLEAN HEALTHY MOUTH IS YOUR RESPONSIBILITY TOO! Your dentist only sees you every so often, and does the work necessary at that time. But it's up to you to protect your teeth and gums between visits.

Besides the two rules that are so familiar to us, "Brush your teeth twice a day, see your dentist twice a year", dental scientists have added a very important third rule. "Remove the plaque from your teeth at least once a day by flossing".

The reason for this new rule? Plaque is the leading cause of tooth decay and gum disease. It's a sticky, almost invisible film that clings to tooth surfaces and is composed of saliva, tissue cells and living bacteria always present in the mouth. It washes into the tiny crevices of the teeth and gums. When you eat food containing carbohydrates such as sugar and starches, the bacteria in the plaque can produce acid. Even though tooth enamel is the hardest substance in the body, this acid can actually dissolve the enamel and cause decay.

Plaque that is not removed can change into a substance called tartar or calculus, which can contribute to periodontal (gum) disease. When calculus builds up, it takes a visit to your dentist to remove it.

**A few rules to follow to keep that smile glowing:**

Brush teeth at least twice a day, and also after meals if possible. At the very least, rinse mouth after meals if brush isn't possible.

Visit the dentist twice a year and follow his instructions.

Remove plaque from teeth at least once every 24 hours by flossing.

Replace a worn out toothbrush. To clean effectively, the bristles must be straight and resilient. Bristles start to wear out in about 4 months.

Use unwaxed dental floss, preferably at night before going to bed. This helps remove the plaque that a toothbrush can't reach.

Avoid sweet foods, especially between meals.

# 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, unless the treatment would have been covered in the absence of the court order.

**Criminal Activities** - Any injury resulting from or occurring during a 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 will not apply to injuries suffered by a Covered Person who is a victim of domestic violence.

**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, Customary and Reasonable fees for services or supplies provided.

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

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 and for which the Covered Person has no legal obligation to pay.

**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.**

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

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

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

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

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

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

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

**Prior 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 hereunder 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.

**Sales Tax, Etc.** - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

**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 such as depression.

**Telecommunications** - Advice or consultation given by or through any form of telecommunication.

**Travel** - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

**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 that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not 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. If the Plan elects to provide benefits for any such condition, the Plan will be entitled to establish a lien upon such other benefits up to the amount paid.

# COORDINATION OF BENEFITS (COB)

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

## DEFINITIONS

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

**Other Plan** - Any other plan, including a medical policy provided by a Covered Person's auto insurer that also provides benefit for expenses covered under This Plan.

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

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

**This Plan** - The coverage provided by this Plan.

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

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

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

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

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

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

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

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

## EFFECT ON BENEFITS UNDER THIS PLAN

**When Other Plan Does Not Contain a COB Provision** - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

**When Other Plan Contains a COB Provision** - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

**NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.**

## ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

**Medicare as an "Other Plan"** - In most instances, the Employer's Group Plan takes a primary payer position to Medicare. A Participant and/or a dependent spouse who is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

secondary for Active Employees and Spouses of Active Employees

secondary for expenses incurred on or after January 1, 1987 by active Employee's, or Dependents of Active Employee's, who are eligible for Medicare because of disability other than for End Stage Renal Disease, and

secondary for the first 30 months after an individual under age 65 begins treatment for End Stage Renal Disease.

Primary the 31st month after an individual under age 65 begins treatment for End Stage Renal Disease.

Primary the date the Employee terminates group coverage, terminates employment, retires or ceases to be in an eligible class for group coverage.

When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits. In no event will this Plan pay more than the regular benefits payable in the absence of other coverage.

**End Stage Renal Disease**: A Covered Person who is is diagnosed with end stage renal disease shall enroll in Medicare. Information regarding Medicare enrollment can be found at:

https://www.medicare.gov/people-like-me/esrd/getting-medicare-with-esrd.html

This Plan's primary payment obligation shall immediately after the thirty (30) month "coordination period" as provided in Medicare law and regulations.

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

**NOTE: This Plan will provide primary medical and prescription drug benefits for spouses when their monthly premium contribution for their employer-sponsored coverage does not exceed 5% of the spouse's monthly gross income, and they are not being compensated for not enrolling in their employer's health plan. For those employers who offer multiple plans, the least expensive plan will be used for this calculation.**

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

either of the parents longer is primary.

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

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

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the noncustodial parent; and then

the plan of the spouse of the noncustodial parent.

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

**Continuation Coverage (COBRA) Enrollee** - If a Participant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

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

## OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

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

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

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

# HOLMAN FAMILY COUNSELING, INC.

Holman reimbursement of out-of-network benefits will be calculated using the UCR for Holman in-network contracted rates, not to exceed provider's billed charges. Patient is responsible for difference between provider's billed charges and Holman reimbursement.

## LATE CANCEL / NO SHOW PENALTY

Except in those cases where the enrollee notifies the contracting/in-network provider at least twenty-four (24) hours in advance that the scheduled session will not be kept, the enrollee will be charged the sum of twenty-five dollars ($25.00) directly by the contracting provider for scheduled sessions that are not kept.

## LIMITATIONS & EXCLUSIONS

The following services and limited or excluded:

Services provided by non-contracted providers except for those that qualify, as emergency behavioral health treatment hospital admissions are not a covered benefit. Any charge in excess of the maximum allowable charge is also not covered.

Services of any kind that are not specifically preauthorized or are in excess of those authorized by HFC are not a covered benefit.

Treatments, which do not meet national standards for behavioral health professional practice, are not a covered benefit.

Treatment sessions provided by computer Internet services are not a covered benefit.

Services or treatment where other group insurance is primary are not a covered benefit.

Evaluations or reports for legal proceedings are not a covered benefit.

Services or treatment provided as a result of any worker's compensation law, or similar legislation, or obtained through or required by any government agency or program whether federal, state or any subdivision thereof (exclusive of Medi-Cal) are not a covered benefit.

Court ordered treatment or therapy ordered or required as a condition of parole, probation, custody, visitation, or forensic evaluations exceeding the benefits of this plan or that are not obtained without prior authorization from HFC may not be a covered benefit.

Court ordered inpatient treatment may not be a covered benefit. Court ordered outpatient treatment would require if approved, a Co-Pay of $40.00 per visit for all outpatient conjoint or day treatment.

Conditions of a Participant that have resisted all reasonable attempts at improvement as determined by the Utilization Management Committee are not a covered benefit.

Mental retardation or autistic disease of childhood, other than to make a primary diagnosis is not a covered benefit.

Psychotherapy used as professional training is not a covered benefit.

Treatment for children performing poorly in school without exhibiting independent mental health problems is not a covered benefit. Tutoring and educational therapy is covered only as an adjunct to required and authorized inpatient treatment and only if parents/guardians are actively involved in the course of treatment. Academic or educational testing, counseling and remediation are not a covered benefit.

Treatment for reading disorders, learning disorders, speech disorders, hearing disorders is not a covered benefit.

Treatment for conduct disorders, oppositional defiant disorders and disruptive behavior disorders, not otherwise specified, of adolescents and children are not a covered benefit except for outpatient therapy. Adolescents must be willing to participate in treatment in order for benefits to be authorized.

Counseling in preparation for or associated with a sex change operation or gastro-intestinal bypass is a covered benefit for assessment only.

Sexual therapy programs that use sexual surrogates are NOT a covered benefit. Therapies for sexual addiction, sexual offenders or perpetrators of sexual violators are a covered benefit in an outpatient setting; subject to limitation #10.

Pastoral or spiritual counseling is NOT a covered benefit by an unlicensed provider.

Dance, poetry, music or art therapy, is NOT a covered benefit.

Non-organic therapies, including but not limited to the following: bioenergetic therapy, confrontation therapy, crystal healing therapy, educational remediation, primal therapy, rolfing, training analysis (traditional, orthodox), Z therapy are not covered benefits.

Organic therapies, including but not limited to the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, sedative action electrostimulation therapy are not covered benefits.

All non-prescription and prescription drugs prescribed in connection with an enrollee's treatment are not a covered benefit.

Transportation services by ground or air ambulance is not a covered benefit, except with prior authorization from HFC when necessary to transfer a Covered Person to a behavioral health professional practice.

Long-term insight-oriented psychotherapies designed to regress the enrollee emotionally or behaviorally are NOT a covered benefit.

Treatment for chronic conditions not reasonably expected to improve with short-term, intensive symptom-focused therapy is not a covered benefit.

Personal enhancement through psychoanalysis or self-actualization therapy is NOT a covered benefit. If the plan has an EAP, EAP can be used for personal enhancement or self-actualization therapy.

Surgery, acupuncture, physical therapy, or occupational therapy are NOT covered benefits.

Neurological services and tests, including but not limited to: EEGs, Pet scans, beam scans, MRIs, skull X-rays, and lumbar punctures are NOT covered benefits.

Evaluation or treatment for education or professional training, investigational purposes related to employment, fitness for duty evaluations for leaves of absence or time off, career personnel counseling, and disability evaluations are NOT a covered benefit if such services are beyond or outside the scope of an established and authorized treatment program.

Treatment for codependency is NOT a covered benefit. If the plan has an EAP, EAP can be used for codependency therapy.

Acute care hospital benefit is limited to when an enrollee is experiencing a behavioral state that supports an enrollee's "reasonable belief" that emergency services were needed for a behavioral health condition. The following mental states are the basis for the Plan's minimum standards of reasonable belief.

Gravely disabled/Imminent suicidal intent/Danger to self

Homicidal intent/Danger to others

Medical detoxification

Medication crisis stabilization

Involuntary hold/Legal form(Note):

**NOTE: Gambling, and stress management are not covered benefits in an acute care hospital. Treatment for those conditions may be provided in a sub acute facility or outpatient setting as determined by HFC's UMC. If the plan has an EAP, EAP can be used for treatment of pathological gambling.)**

Inpatient acute hospital ancillary services need specific authorization and are limited as follows:

One professional contact or medical management session per day of authorized hospital stay.

Aversion therapy is not covered.

Experimental or nontraditional use of medication is not covered.

Psychological testing must be specifically preauthorized.

Home/Therapeutic passes terminate any existing authorization for hospital stay. Following a Home/Therapeutic pass, treatment will be considered a covered benefit in a non-hospital setting.

Ingenix: The Plan requires HFC to use RBRVS (professional) and DRGs (hospital) to calculate reimbursement for Non-Contracted Providers. Any disputes are to be negotiated directly with Holman Family Counseling. Every effort will be made to assure Plan Participants are not subject to balance billing practices for covered services. Final appeal should be made to the Plan Trustees. RBRVS and DRGs are government approved reimbursement calculations for the reasonable and customary value of healthcare services rendered. They are based upon statistically credible information that is updated at least annually and takes into consideration:

The provider's training qualifications, and length of time in practice

The nature of services provided

The fees usually charged by the provider

Prevailing provider rates charged in general geographic areas in which services were rendered

Other aspects of the economics of the medical provider's practice that are relevant, and

Any unusual circumstances in the case.

All inpatient mental health services and substance dependency or abuse is subject to Utilization and Case Management by the Plan's assigned Medical Director. Utilization Review includes prior authorization of any non-emergency inpatient services. Additionally, inpatient services are subject to concurrent review to determine the Medical Necessity efficacy standards of the Plan. The Plan will only pay for services that are Medically Necessary. The parent(s) or guardian(s) must be actively involved in the course of treatment when the minor dependent is in Residential inpatient, care group homes, halfway house and day treatment benefits or benefits may not be considered Medically Necessary. Active participation will be determined within the concurrent review of the Utilization Review Department. Active involvement in the course of treatment will vary according to the particular patient or treatment plan. In each case the parent or guardian will be presented with the recommended participation, their participation will be discussed, explained and negotiated with the parent or guardian. Active participation may include attending family sessions at the program that is treating the adolescent, attending self-help groups and participating in individual, conjoint, or family therapy.

The treatment plan for parents or guardians will be presented to parents/guardians for their signature. Refusing to follow the treatment plan for parents or guardians may result in reduction in benefits. (Refer to Parent/Guardian Treatment Agreements).

Active participation may include attending family sessions at the program that is treating the adolescent, attending self-help groups and participating in individual, conjoint, or family therapy.

The treatment plan for parents or guardians will be presented to parents/guardians for their signature. Refusing to follow the treatment plan for parents or guardians may result in reduction in benefits (Refer to Parent/Guardian Treatment Agreements).

Bio-feedback and Neuro-feedback must be specifically preauthorized.

Substance related diagnoses are defined as follows:

Substance dependency and substance abuse, as well as the substance-induced disorder(s), when there is evidence from the history, physical exam, or laboratory findings of drugs, of abuse during inpatient or outpatient treatment. Because the withdrawal state for some substances can be relatively protracted, it is useful to carefully observe the course of symptoms for an extended period of time (e.g. four weeks or more) after the cessation of acute intoxication, withdrawal, and dissipation of symptoms, making all possible efforts to maintain the eligible's abstinence in various ways. These efforts shall include inpatient hospitalization or residential treatment, acute care, sub acute care, intensive outpatient and sober living care, requiring frequent follow-up visits, and shall also include recruiting friends and family members to help keep the eligible substance free. Regular urine or blood tests for the presence of substances will also be required.

When there is no recent physical or laboratory evidence of a substance-related disorder, and there is evidence from history, and substance related symptoms continue in a prolonged or permanent persistence, long after the usual course of intoxication or withdrawal would/has ended, then this describes a substance-induced persisting disorder. A substance-induced persisting disorder for purposes of this group plan contract is a covered benefit under the substance abuse benefit. (From Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, pages 192-193).

Anorexia Nervosa/Bulimia nervosa and Autism: As outlined in the American Psychiatric Association guidelines, this benefit plan provides for treatment of Anorexia Nervosa, Bulimia Nervosa and Autism utilizing a split management approach where medical carrier and providers (e.g., specialists in internal medicine, pediatrics, adolescent medicine, speech & language therapy and occupational therapy,) manage general medical issues, such as nutrition, weight gain, exercise, eating patterns and speech and language problems, while the mental health plan and providers address psychiatric and psychological issues. The coordinated care plan requires the collaboration of a variety of professionals to provide nutritional counseling and clinical assessment, work with the family, set up behavioral programs, address dysfunctional thoughts, feelings and beliefs, correct defects in affect, improve associated psychological difficulties, enlist family support and participation in treatment and prevent relapse. Any hospitalization and/or outpatient treatment which is required to restore patient's weight, address fluid and electrolyte imbalances, treat superior mesenteric artery syndrome, esophageal tears, gastric ruptures, cardiac arrhythmias, Kleine-Levin syndrome, normochomic normocytic anemia, impaired renal functioning, cardiovascular problems, dental problems and osteoporosis, learning problems, speech problems, vocational or occupational problems or any other type of medical disorder is NOT a covered benefit of The Holman Group, but, is covered under the Medical Plan Benefits, if Medically Necessary.

Treatment for weight reduction or the treatment of obesity is NOT a covered benefit. Weight management, smoking cessation or reduction, nicotine use or addition and personal health maintenance issues can be referred to WellCall for health-coaching services. (WellCall is an upgraded service to the EAP).

# VISION CARE PLAN
## (MEDICAL EYE SERVICES)

The following vision care benefits are provided through the Medical Eye Services, Inc. vision network (MES). Covered Persons should refer to the MES directory for a list of Participating Providers. Not all Providers participate for all services. It is a Covered Person's responsibility to verify the Participating status of the Provider with the service Provider prior to receiving services.

## HOW TO USE THE PLAN

When a Covered Person selects an eye care provider from the MES list; the vision benefits described below under Participating Providers will be provided. Any additional care, service and/or materials not covered by this plan may be arranged between the Covered Person and his optometrist.

- Select a Medical Eye Service Provider.
- Take a Medical Eye Services claim form to the eye care provider of choice. **If a Covered Person does not bring a claim form with him at the time of the visit, he may be required to pay in full for the services**.
- For questions and answers about the plan, contact Medical Eye Services at:

**(800) 877-6372**
**P O Box 25209**
**Santa Ana, CA 92799**

- For services at a Non-Participating Provider, the Covered Person or the Provider should submit an itemized billing and a copy of his prescription with the claim form to Medical Eye Services.
- The Non-Participating Provider reimbursement will be made to the Covered Person up to the Schedule of Allowances. The Exam reimbursement is limited to the lesser of the benefit maximum or the amount charged, less the deductible.

## SCHEDULE OF ALLOWANCES FOR PARTICIPATING ("NETWORK") PROVIDERS

| | |
|---|---|
| Comprehensive Examination | $15 Co-Pay per Eligible Employee or Dependent |
| Regular Lenses | No Additional Cost for Standard Lenses with an eye size < 61mm |
| Standard Frames | No Additional Cost for Standard Frames up to $125 retail |
| Contact Lenses | No additional Cost for Medically Necessary Contacts – see **NOTE**<br><br>If Contact Lenses are for Cosmetic purposes, the Plan will pay $130 toward their cost, any balance is the Covered Person's responsibility. |
| Tint | $40 Allowance |

**NOTE: "Medically Necessary Contacts" are those approved in advance by MES: (a) following cataract surgery, (b) to correct extreme visual acuity problems that cannot be corrected to 20/70 in the better eye except by their use, (c) certain conditions of Anisometropia, or (d) Keratoconus.**

**When a Covered Peron selects a doctor from the MES list, the vision benefits described above (examination, professional services, lenses and frames) will be provided. Any additional care, service and/or materials not covered by this Plan may be arranged between the Covered Person and his optometrist.**

# SUBROGATION AND REIMBURSEMENT, THIRD PARTY RECOVERY

**Benefits Subject to This Provision**
This provision shall apply to all benefits provided under any section of this Plan.

**When This Provision Applies**
A Covered Person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

execute and deliver a Subrogation and Reimbursement Agreement;

authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid;

immediately reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

**Amount Subject to Subrogation or Reimbursement**
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

**When a Covered Person Retains an Attorney**
The Covered Person agrees not to retain an attorney who does not recognize and consent to the fact that the Plan precludes the operation of the "made-whole'' and "common fund" doctrines, and as such, will not assert either doctrine against the Plan's lien. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his or her attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

**When the Covered Person is a Minor or is Deceased**
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

**When a Covered Person Does Not Comply**
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

**Defined Terms for Subrogation:**

Another Party **-** Any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Person **-** Anyone covered under the Plan, including minor Dependents.

Recovery **-** Any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Reimbursement **-** Repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

Subrogation - The Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

# ELIGIBILITY AND EFFECTIVE DATES

**Eligibility Requirements - Employees & Trustees**
To participate as an Employee in the Plan described herein, an individual must be in active employment for the Employer, performing all customary duties of his or her occupation at his usual place of employment (or at a location to which the business of the Employer requires him or her to travel). Trustees are eligible for the benefits of this Plan while holding an active elected position as a Trustee of the Central Unified School District.

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). 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.

**Note:** Non-contracted employees must meet the requirements of the PPACA to be eligible for the Bronze Plan, Medical and Prescription Plan.

**Effective Date - Employees**
A new Employee will have coverage effective on the first of the month following or coincident with his commencement of active employment. To become covered, the Employee must also fill out the necessary enrollment form for himself and any dependents to be covered, and sign the forms to authorize payroll deduction of any required Employee contribution to the Plan.

If an Employee fails to enroll within thirty-one (31) days of his employment, his coverage can become effective only in accordance with the “Late Enrollment” or “Special Enrollment Rights” provisions below.

**Eligibility Requirements – Dependents**
An eligible Dependent of an Employee is:

**NOTE: Spouse or Registered Domestic Partner is available only with the Gold Plan Benefits option).**

a legally married spouse. The marriage must meet all requirements of a valid marriage contract in the Employee’s state of residence and will not include a common law spouse.

a registered domestic partner when the partner and Employee have registered their domestic partnership with the Secretary of State of the State of California. The State of California permits state registration of: (1) same-sex domestic partnerships, and (2) opposite-sex partnerships after one partner attains age 62. A domestic partnership registration from outside of California will be recognized on the same basis as a California state-registered domestic partnership only if the out-of-California partnership is a legal union of two persons, other than a marriage, and is substantially equivalent to a registered California domestic partnership. This applies regardless of whether it bears the name “domestic partnership.” Domestic partners who register only with their cities, counties or employers are not eligible;

a child who is under age 26 (i.e., through age 25). 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 foster child or a grandchild or other child placed under the court-appointed legal guardianship of the Employee. An eligible child also includes one for whom coverage is required due to a Qualified Medical Child Support Order.

A person who qualifies as both an Employee and a Dependent, is eligible to be covered as an Employee and a Dependent. When both husband and wife are covered as Employees, both parents may enroll eligible children and Coordination of Benefit Rules will apply.

**To enroll Dependents, You will be required to provide proper documentation as approved by the Plan Administrator (marriage license, birth certificate, adoption order, official copy of recent tax return obtained directly from the state or Internal Revenue Service, OR a signed and notarized affidavit ONLY IF the prior four (4) items are unavailable).**

The Plan Administrator or Contract Administrator has the right to request information needed to determine an individual's eligibility for benefits under the Plan.

**NOTES: An eligible Dependent does <u>not</u> include:**

- **a spouse or domestic partner following legal separation or a final decree of dissolution 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 eligibility.**

**An eligible Employee does not include one who is eligible for Medicare by reason of age and who has elected Medicare coverage in lieu of Plan coverage.**

**Effective Date - Employees**
New Employees will be informed of their effective date by their Employer upon completion of the enrollment forms. If an Employee fails to enroll within thirty (30) days of his employment his coverage can become effective only in accordance with the "Late Enrollment" or "Special Enrollment Rights" provisions below.

**Effective Date - Dependents**
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 (30) days of their eligibility date. See the "Special Enrollment Rights..." provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment/Re-Enrollment" provision.

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.

**NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.**

**Special Enrollment Rights & Mid-Year Election Change Allowances**
<u>Entitlement to Enroll Due to Loss of Other Coverage</u> - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage hereunder 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, on or after April 1, 2009, 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-one (31) 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 to Enroll Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, domestic partnership, 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 **NOTES**:

where Employee's marriage or domestic partnership is the "triggering event" - the spouse's or partner's coverage (and the coverage of any newly eligible children) will be effective on the date of event;

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 or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse (or domestic partner) 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 other enrollment allowances.**

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse (or domestic partner) is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be qualified (QMCSO). A request to enroll the child may be made by the Employee, the Employee's spouse (or domestic partner), the child's other parent, or by a State Agency on the child's behalf. 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.

**Reinstatement / Rehire**

An Employee returning to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) will be reinstated to coverage under the Plan to the extent required by law.

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

**NOTE: Except in the above instances, any terminated Employee who is rehired after a break in service of more than thirteen (13) weeks will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.**

**Transfer of Coverage**

If spouses (or domestic partner) are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse (or domestic partner) 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 under the Plan will terminate upon the earliest of the following:

termination of the Plan or termination of the Plan benefits as described herein;

Employee's termination of eligibility or termination of employment;

Employee's election to terminate participation, unless prohibited by law (i.e., when election changes cannot be made due to IRC section 125 "change in status" guidelines);

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 or ceases to be eligible as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

the date the Employee dies.

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

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

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

termination of the coverage of the Employee;

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

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

**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.**

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

# EXTENSIONS OF COVERAGE

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

**Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children**
If 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;
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness;
- the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and
- such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained age 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 proof of the child's incapacity to the Plan Sponsor three (3) months prior to his 26th birthday from his attending physician and again to the Contract Administrator within thirty-one (31) days of the child's attainment of the limiting age. The Plan requires that proof of continuous disability be re-certified periodically at the request of the Plan Sponsor and/or the Contract Administrator but not more than once each Calendar Year.

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

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

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

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

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

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

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

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

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

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

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

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

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the 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 which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

**NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" 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 service member medically unfit to perform his or her duties).**

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

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

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

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

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

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

24 months; or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - An employee returning from active military service and who is subject to a collective bargaining agreement should refer to that collective bargaining agreement for information.

For any other employee and regardless of whether the employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

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

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

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

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

When coverage 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 During Labor Dispute**
If an Employee fails to continue in active employment due to a labor dispute, 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 for Retirees**
If an Employee retires from active service from the Employer, he should refer to their individual collective bargaining agreement.

The retiree will be required to contribute to the Plan at rates determined by the Plan Sponsor. Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants.

**NOTE: Only those individuals who were covered hereunder on the day immediately prior to the Employee's retirement will be eligible for continued coverage under the terms of this provision, except that HIPAA's special enrollment rights will extend to retirees who acquire new Dependents. Also, this Plan will be secondary to Medicare for any such individuals who are eligible for Medicare - see Coordination of Benefits section for more information.**

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

# EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If, on the date coverage terminates (as determined by the **Termination of Coverage** section), an Employee or Dependent is Totally Disabled, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

upon termination of the Total Disability;

twelve (12) months following the date coverage terminated;

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

upon termination of the Plan;

the date the Insurance Contract(s) and/or Reinsurance Contract(s) issued to the Plan is terminated;

the end of the period for which any required contributions for extended benefits have not been paid.

With reference to an Employee, "Total Disability" or "Totally Disabled " means a disability resulting solely from a sickness, injury or pregnancy that prevents the Employee from performing every duty pertaining to his or her occupation or engaging in any other type of work for remuneration. For a Dependent, it is disability that prevents Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. The Physician's written certification of the Total Disability must be received by the Plan within 90 days after coverage is terminated and at 90 day intervals thereafter. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

**NOTE: If a Covered Person is eligible for and elects COBRA continuation coverage under the terms of the section entitled COBRA Continuation Coverage, coverage will be provided for ALL CONDITIONS and not just the disabling condition. However, this Extension of Benefits will run concurrently with such COBRA coverage and WILL NOT operate to extend the COBRA maximum period.**

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

# CLAIMS PROCEDURES

## SUBMITTING A CLAIM

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

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

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

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

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim should be submitted to the claims office ninety (90) days after expenses are incurred. Failure to furnish complete proof of loss within the time required will not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided proof of loss is furnished as soon as reasonably possible and, unless the Claimant is legally incapacitated, within 365 days from the date on which the covered charges were incurred. Otherwise the Claim will be denied due to untimely submission. Claim forms are not necessary. The Claims Administrator will accept most bill forms from the Provider, as long as the information indicated at the top of this page is contained on the billing form.

   A Post-Service Claim should be submitted to:

   **Anthem Blue Cross**
   **PO Box 60004**
   **Los Angeles, CA 90060-8007**

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

## ASSIGNMENTS TO PROVIDERS

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

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

**In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.**

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

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

## CLAIMS TIME LIMITS AND ALLOWANCES

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

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

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

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

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

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

| "POST-SERVICE" CLAIM ACTIVITY | TIME LIMIT OR ALLOWANCE |
|---|---|
| Claimant Makes Initial Incomplete Claim Request | Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request. |
| Plan Receives Completing Information | Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. |
| Claimant Makes Initial Complete Claim Request | Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. |
| Claimant Appeals | See "Appeals Procedures" subsection. |
| Plan Responds to Appeal | Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels). |
| "Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period. | |

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

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

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

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

## ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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

name of health care provider

the diagnosis code and its corresponding meaning

the treatment code and its corresponding meaning

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

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

a description of available internal appeals and external review processes

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

## INTERNAL APPEAL PROCEDURES

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

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

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

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

the specific reason(s) for the decision;

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

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

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

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

information about the external appeals process

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

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

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

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

## EXTERNAL REVIEW PROCEDURES

**Filing an External Review**
An individual may file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is not corresponding date four months after the date of receipt (e.g. February 28), the request must be filed by the first day of the fifth month following receipt of the notice. The request is filed as described in the notice.

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

- the Claimant is or was covered by the Plan at the time the health care service was requested;
- the Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Claimant’s failure to meet the requirements for eligibility under the terms of the Plan;
- the Claimant has exhausted the Plan’s internal appeal process, unless the Claimant is not required to exhaust the internal appeals process; and
- the Claimant has provided all of the information and forms required to process an external review.

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

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

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

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

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

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

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

# DEFINITIONS

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

**Accidental Injury** - Any accidental bodily injury 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.

**Allowable Charge(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.

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

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

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

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

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

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

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

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

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

has organized facilities for birth services on its premises;

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

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

maintains daily clinical records.

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

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

**Contract Administrator** - A company that performs all functions reasonably related to the general management, supervision and administration of one or more benefits of the Plan in accordance with the terms and conditions of 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"

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

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

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

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

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

and who is a/an:

Acupuncturist (CA)
Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dental Hygienist
Dentist (DDS or DMD)
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Vocational Nurse (LVN)
Nurse Practitioner
Occupational Therapist (OTR)
Optician
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Physician Assistant (PA)
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatric mental health nurse
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:

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

licensed Outpatient mental health facilities;

freestanding public health facilities;

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

enuresis control centers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

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

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

**Emergency** - see "Medical Emergency"

**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.

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

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

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

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

maintains a complete medical record on each patient;

has a full-time administrator.

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

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

**Hospital** - An institution that:

maintains permanent facilities for care of resident patients;

has a licensed Physician on duty;

has a facility for major surgery;

provides 24-hour-a-day nursing by registered nurses (RNs);

operates lawfully in the area in which it is located and is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals;

primarily provides diagnostic and therapeutic medical care on a basis other than a rest home, nursing home, convalescent hospital, home for the aged, or a facility for the treatment of alcoholism or drug addiction.

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

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

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

**Medical Emergency** - An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

**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 or a covered mental health condition or a covered substance use disorder;

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

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

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

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

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

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

**Mental Nervous Disorder Treatment Facility** - An institution that primarily provides a program for the diagnosis, evaluation and effective treatment of mental disorders and that is not primarily a school or a custodial, recreational or training institution. It must be supervised full-time by a psychiatrist responsible for patient care who is there regularly and it must be staffed by psychiatric Physicians involved in care and treatment. It should provide infirmary–level medical services and provide or arrange with a Hospital in the area for any other required medical service.

A written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a psychiatric Physician, is required. The facility must meet standard licensing requirements for the state.

**Negotiated Rate** - The rate determined for a Network Provider that represents an amount less than or equal to the provider’s normal charges. A Participant is not responsible for the difference between the Providers billed charges and the Negotiated Rate.

**Outpatient -** Medical care rendered other than as an Inpatient basis at a Hospital or at a Covered non-Hospital facility.

**Participant** - see “Covered Person”

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

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

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

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

**Plan Administrator** - see "Plan Sponsor"

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

**Plan Sponsor** - The entity sponsoring the Plan. 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.

**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 85% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

**Sickness** - Bodily illness or disease (including covered mental health conditions and covered substance use disorders as required under the federal Mental Health Parity and Addiction Equity act of 2008), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician or other appropriate Covered Provider in order to be considered a Sickness hereunder.

**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.

**Substance Abuse Treatment Facility / Chemical Dependency Treatment Facility** - An institution primarily providing a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse, making charges and meeting licensing standards.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based upon medical, psychological and social needs. The facility must be supervised by a Physician and: (1) provide detoxification services, (2) provide infirmary level medical services, (3) provide or arrange with a Hospital in the area for any medically-required services, and (4) provide supervision by a staff of Physicians.

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

a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times; X-ray and laboratory equipment and a life support system.

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

**Usual, Customary and Reasonable (UCR)** - A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated and is considered a reasonable charge by the Plan Administrator. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, Usual and Customary will mean the provider's negotiated rate but not to exceed the non-Network Usual and Customary allowance.

**NOTES: U&C for multiple surgical procedures is determined as follows:**

**if surgeries are necessitated by multiple traumatic injuries and are performed by one (1) or more Physicians during the same operative session, U&C will be 100% of the U&C allowance for each procedure performed on a separate body area or system, and 70% of the U&C allowance for any secondary procedure performed on such body area or system;**

**in non-injury situations, if multiple surgical procedures are performed by one (1) or more Physicians during the same operative session, U&C will be 100% of the U&C allowance for the primary procedure, 70% of the U&C allowance for the secondary procedure, and 25% of the U&C allowance for the third and any other procedure.**

**if bilateral surgical procedures are performed by one (1) or more Physicians during the same operative session, U&C will be 100% of the U&C allowance for the primary procedure plus 70% of the U&C allowance for the second (bilateral) procedure.**

**The U&C allowance for an assistant surgeon will be 25% of the U&C allowance for the primary surgeon.**

**If co-surgeons are Medically Necessary for a procedure and each Physician is a primary surgeon, U&C for each surgeon will be 100% of the U&C allowance.**

**In no instance will Usual and Customary exceed a provider's actual charge.**

**Waiting Period** - Any period of time imposed by the Plan between the first day of employment and the first day of eligibility for coverage under the Plan.

# GENERAL PLAN INFORMATION

| | |
|---|---|
| **Name of Plan:** | **Central Unified School District Employee Benefit Plan** |
| **Plan Sponsor / Plan Administrator:** | **Central Unified School District** |
| Address: | 4605 North Polk Avenue<br>Fresno, CA 93722 |
| Business Phone Number: | (559) 274-4700 |
| **Participating Employer(s):** | **Central Unified School District** |
| **Plan Sponsor ID Number (EIN):** | **77-0559747** |
| **Plan Number:** | **501** |
| **Plan Year:** | **December 1 through November 30th** |
| **Named Fiduciary:** | **Central Unified School District** |
| Address: | 4605 North Polk Avenue<br>Fresno, CA 93722 |
| (See also definition of "Fiduciary") | |
| **Agent for Service of Legal Process:** | **Kelly Porterfield, CBO**<br>**Central Unified School District** |
| Address: | 4605 North Polk Avenue<br>Fresno, CA 93722 |

(Legal process may be served upon the Plan Administrator or a Fiduciary)

| | |
|---|---|
| **Privacy Officer:** | **Leslie Hertzig, Vice President**<br>Advantek Benefit Administrators |
| Mailing Address: | P.O. Box 45007<br>Fresno, CA 93718 |
| Phone: | (866) 556-7655 |
| **Type of Plan:** | **This is an employee welfare benefit plan providing group benefits** |
| **Plan Benefits Described Herein:** | **Self-Funded Medical, Prescription, Dental and Vision Benefits** |
| **Type of Administration:** | **Contract Administration** - see "Administrative Provisions" for additional information |
| **Contract Administrator:** | **Advantek Benefit Administrators** |
| Mailing Address: | P. O. Box 45007<br>Fresno, CA 93718 |
| Phone: | (866) 556-7655 |

## FUNDING - SOURCES AND USES

**Employee & Employer Obligations**

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

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

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan Participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer. If Plan benefits are part of an Employer-sponsored cafeteria plan under Section 125 of the Internal Revenue Code, such coverage costs may be deducted on a pre-tax basis.

## 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 Administrator'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 Covered Person or beneficiary:

reduce, modify or terminate retiree health care benefits hereunder, if any;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; 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 Plan benefits to which he has become entitled.

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

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

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

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

**Discretionary Authority**
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a

Covered Persons rights; and to determine all questions of fact and law arising under the Plan.

**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 Administrator 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 therefor under the Plan.

**Fiduciary Responsibility & Authority**
Fiduciaries will serve at the discretion of the Plan Administrator 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 Administrator 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.

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 Covered Person 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 Covered Person'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 Covered Person 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," Covered Persons and beneficiaries must be furnished a Notice of Modification reflecting the change not later than 60 days prior to the effective date of the change, or 30 days before the Plan Year anniversary date, whichever is earlier, if such change is a benefit required to be detailed in the Summary of Benefits and Coverage. All other material reductions shall be provided by written notice no later than 60 days after the adoption of the change, unless you provide summaries of modifications or changes at regular intervals of not more than 90 days. Any such amendment shall be binding upon all Covered Persons (including those Covered Persons on continuation coverage). "Material modifications" are those that would be construed by the average Covered Person as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

"Material modifications" are those which would be construed by the average Covered Person 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 Covered Person or beneficiary, (3) modifies the information described in the SBC or (4) 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.

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

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

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

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

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

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

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

NOTES: The Privacy Rules requirements do not apply to "summary health information" which is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is health-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

See Appendix for **HIPAA Privacy and Security**.

**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 Administrator 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 therefor 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**
Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

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

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

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

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

The Plan Administrator will retroactively rescind the benefits and/or coverage under this Plan, upon 30 days written notice to the Participant, for any intentional material misrepresentation, as determined by the Plan Administrator, Plan Sponsor, or Contract Administrator, or fraud committed by the Participant and relied upon to the detriment of the Plan Administrator, Plan Sponsor, or Contract Administrator in providing coverage and/or benefits under the Plan.

**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.

**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.

**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 (as defined by the federal Defense of Marriage Act) 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).

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).

**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. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See **NOTE**.

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

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

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

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

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

**NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.**

**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 is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the 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 will be charged 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. If payment is not made within such time period, the COBRA election is null and void. The initial premium 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. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

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

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

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

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which 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) which 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.**

**See the "Effect of the Trade Act" provision for additional cost of coverage 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 loss of coverage due to 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;

for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to 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 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.

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 be disabled in 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 period. 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 loss of coverage due to 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 becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

**Effect of the Trade Act -** In response to Public Law 107-210, referred to as the Trade Act of 2002 (“TAA”), the Plan is deemed to be “Qualified Health Insurance” pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation (“PBGC”), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

Applicable Cost of Coverage Payments
Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

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## CALIFORNIA-COBRA ("CAL-COBRA") CONTINUATION

Although the self-funded benefits described herein are not subject to state insurance requirements, the Plan Sponsor has elected to provided extended coverage as prescribed in Article 4.5 of the California Health and Safety Code and Article 1.7 of the California Insurance Code.

Such extended coverage will be allowed for California enrollees so that such enrollees will have the opportunity to purchase up to a total of 36 months of extended coverage (COBRA and Cal-COBRA combined).

# COBRA NOTIFICATION PROCEDURES

## COBRA NOTICE REQUIREMENTS FOR PLAN PARTICIPANTS

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is:

A Dependent child's ceasing to be eligible (e.g., due to reaching the maximum age limit);

the divorce or legal separation of the Employee from his/her spouse;

the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to **COBRA Continuation Coverage** with a maximum duration of 18 (or 29) months;

where a Qualified Beneficiary entitled to receive **COBRA Continuation Coverage** with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled in the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date the document was prepared and a Qualified Beneficiary should make certain that procedure changes have not occurred before relying on this information. The most current information should be included in the Employer's COBRA Initial General Notice that is provided to new hires.

Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

**Notification & Delivery** - Notification of the Qualifying Event must be provided to the Employer's Human Resources department. Notification should be made in writing.

**Content** - Notification should include evidence that a Qualifying Event or other event extending coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

**Time Requirements for Notification** - Should an event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee, other Qualified Beneficiary, or a representative acting on behalf of any such person) must provide Notice to the designated recipient within 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 – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Also, Notice must be provided within the 18-month COBRA coverage period.

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.

# APPENDIX FOR FEDERALLY-REQUIRED PREVENTIVE CARE BENEFITS

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

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

**Screening may be covered, but active treatment may be excluded under the plan. Please check the benefits for further information.**

**Preventive Services for Adults**

| | |
|---|---|
| **Abdominal Aortic Aneurysm** | one-time screening for men of specified ages who have ever smoked |
| **Alcohol Misuse** | screening and counseling |
| **Aspirin** | use for men and women of certain ages |
| **Blood Pressure** | screening for all adults |
| **Cholesterol** | screening for adults of certain ages or at higher risk |
| **Colorectal Cancer** | screening for adults over 50. Includes prior specialist consult and pathology exam on a polyp biopsy. |
| **Depression** | screening for adults |
| **Type 2 Diabetes** | screening for adults with high blood pressure |
| **Diet** | counseling for adults at higher risk for chronic disease |
| **HIV** | screening for all adults at higher risk |
| **Immunization** | vaccines for adults--doses, recommended ages, and recommended populations vary:<br>- Hepatitis A<br>- Hepatitis B<br>- Herpes Zoster<br>- Human Papillomavirus<br>- Influenza (Flu Shot)<br>- Measles, Mumps, Rubella<br>- Meningococcal<br>- Pneumococcal<br>- Tetanus, Diphtheria, Pertussis<br>- Varicella<br>Link for more information on immunizations: http://www.healthcare.gov/news/factsheets/2010/09/affordable-care-act-immunization.html |
| **Obesity** | screening and counseling for all adults |
| **Sexually Transmitted Infection (STI)** | prevention counseling for adults at higher risk |
| **Tobacco Use** | screening for all adults and cessation interventions for tobacco users. Medications prescribed and delivered through retail pharmacy vendor. Limits apply. |
| **Syphilis** | screening for all adults at higher risk |

**Preventive Services for Women, Including Pregnant Women**

| | |
|---|---|
| **Anemia** | screening on a routine basis for pregnant women |
| **Bacteriuria** | urinary tract or other infection screening for pregnant women |
| **BRCA** | counseling about genetic testing for women at higher risk |
| **Breast Cancer Mammography** | screenings every 1 to 2 years for women over 40 |
| **Breast Cancer Chemoprevention** | counseling for women at higher risk |
| **Breastfeeding** | comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women |
| **Cervical Cancer** | screening for sexually active women |
| **Chlamydia Infection** | screening for younger women and other women at higher risk |
| **Contraception** | Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs |
| **Domestic and interpersonal violence** | screening and counseling for all women |

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| **Folic Acid** | supplements for women who may become pregnant |
| **Gestational diabetes** | screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes |
| **Gonorrhea** | screening for all women at higher risk |
| **Hepatitis B** | screening for pregnant women at their first prenatal visit |
| **Human Immunodeficiency Virus (HIV)** | screening and counseling for sexually active women |
| **Human Papillomavirus (HPV) DNA Test** | high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older |
| **Osteoporosis** | screening for women over age 60 depending on risk factors |
| **Rh Incompatibility** | screening for all pregnant women and follow-up testing for women at higher risk |
| **Tobacco Use** | screening interventions for all women, and expanded counseling for pregnant tobacco users. Medications prescribed and delivered through retail pharmacy vendor. Limits apply. |
| **Sexually Transmitted Infections (STI)** | counseling for sexually active women |
| **Syphilis** | screening for all pregnant women or other women at increased risk |
| **Well-woman visits** | Well-woman visits to obtain recommended preventive services |

**Preventive Services for Children**

| | |
|---|---|
| **Alcohol and Drug Use** | assessments for adolescents |
| **Autism** | screening for children at 18 and 24 months |
| **Behavioral** | assessments for children of all ages<br>Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. |
| **Blood Pressure** | screening for children<br>Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. |
| **Cervical Dysplasia** | screening for sexually active females |
| **Congenital Hypothyroidism** | screening for newborns |
| **Depression** | screening for adolescents |
| **Developmental** | screening for children under age 3, and surveillance throughout childhood |
| **Dyslipidemia** | screening for children at higher risk of lipid disorders<br>Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. |
| **Fluoride Chemoprevention** | supplements for children without fluoride in their water source |
| **Gonorrhea** | preventive medication for the eyes of all newborns |
| **Hearing** | screening for all newborns |
| **Height, Weight and Body Mass Index** | measurements for children<br>Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. |
| **Hematocrit or Hemoglobin** | screening for children |
| **Hemoglobinopathies** | or sickle cell screening for newborns |
| **HIV** | screening for adolescents at higher risk |
| **Immunization** | vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:<br>- Diphtheria, Tetanus, Pertussis<br>- Haemophilus influenzae type b<br>- Hepatitis A<br>- Hepatitis B<br>- Human Papillomavirus<br>- Inactivated Poliovirus<br>- Influenza (Flu Shot)<br>- Measles, Mumps, Rubella<br>- Meningococcal<br>- Pneumococcal<br>- Rotavirus<br>- Varicella<br>Link for more information on immunizations:<br>http://www.healthcare.gov/news/factsheets/2010/09/affordable-care-act-immunization.html |
| **Iron** | supplements for children ages 6 to 12 months at risk for anemia |
| **Lead** | screening for children at risk of exposure |
| **Medical History** | for all children throughout development |

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|---|---|
| | Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. |
| **Obesity** | screening and counseling |
| **Oral Health** | risk assessment for young children<br>Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years. |
| **Phenylketonuria (PKU)** | screening for this genetic disorder in newborns |
| **Sexually Transmitted Infection (STI)** | prevention counseling and screening for adolescents at higher risk |
| **Tuberculin** | testing for children at higher risk of tuberculosis<br>Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years. |
| **Vision** | screening for children ages one to five |

**IMPORTANT DETAILS:**

- Be aware that the Plan is only required to provide these preventive services through a Network provider.
- A doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that the plan can require the Covered Person to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if the doctor bills the claimant for the preventive service separately from the office visit.
- For questions about whether these provisions apply to this group health plan, contact the Plan Sponsor or Contract/Claims/Third Party Administrator.
- A Covered Person should ask his health care provider to help him understand which covered preventive services are right for him – based on his age, gender and health status.

**WEBSITE REFERENCES:**

- **Regulation:** http://www.uspreventiveservicestaskforce.org
- **Overview:** https://www.healthcare.gov

# HIPAA PRIVACY

**Commitment to Protecting Health Information**

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

the Plan's disclosures and uses of PHI;

the Covered Person's privacy rights with respect to his/her PHI;

the Plan's duties with respect to his/her PHI;

the eligible Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and

the person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

**How Health Information May be Used and Disclosed**

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

to carry out Payment of benefits;

for Health Care Operations;

for Treatment purposes; or

if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

**Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes**

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

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

ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

the following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

in the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Sponsor will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

**Disclosure of Summary Health Information to the Plan Sponsor**

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

**Disclosure of Certain Enrollment Information to the Plan Sponsor**

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Sponsor or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

**Other Disclosures and Uses of PHI:**

**Primary Uses and Disclosures of PHI**

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

**Other Possible Uses and Disclosures of PHI**

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities; and

locate and notify persons of recalls of products they may be using; and (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

**Required Disclosures of PHI**

Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

**Rights to Individuals**

The Covered Person has the following rights regarding PHI about him/her:

Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.

Copy of this Notice: The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person

of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator.

Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request.

**Questions or Complaints**

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

**Contact Information**

Privacy Compliance Coordinator Contact Information:

Leslie Hertzig
P.O. Box 45007
Fresno, CA 93718
(866) 556-7655

# HIPAA SECURITY

**Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions**

**STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")**
The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

**Definitions;**
*"Electronic Protected Health Information"* (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

*"Security Incidents"* is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

**Plan Sponsor Obligations**
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

report to the Plan any security incident of which it becomes aware.

**Notification Requirements in the Event of a Breach of Unsecured PHI**
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach.

notify the media if the breach affected more than five-hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.

notify the HHS Secretary if the breach involves five-hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five-hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each calendar year.

when a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.