

PERALTA COMMUNITY COLLEGE DISTRICT

PPO TRADITIONAL AND PPO LITE PLAN
ACTIVE AND POST JULY 1, 2012 RETIREES

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date: July 1, 2014

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ADOPTION

Peralta Community College District has caused this Peralta Community College District PPO Traditional and PPO Lite Active and Post July 1, 2012 Retirees Employee Benefit Plan (*Plan*) to take effect as of the first day of July 2014, at Oakland, CA. This is a revision of the *Plan* previously adopted September 1, 2004. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Peralta Community College District.

BY: _____

DATE: _____

SUMMARY PLAN DESCRIPTION

Name of Plan:

Peralta Community College District PPO Traditional and PPO Lite Active and Post July 1, 2012 Retirees Employee Benefit Plan

Name, Address and Phone Number of Employer/Plan Sponsor:

Peralta Community College District
333 East Eighth Street
Oakland, CA 94606
(510) 466-7229

Employer Identification Number:

94-1590799

Plan Number:

502

Group Number:

4138

Type of Plan:

Welfare Benefit Plan: medical, prescription drug and vision benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the *Plan* is provided through one or more companies contracted by the *employer* and shall hereinafter be referred to as the *claims processor*.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Peralta Community College District
333 East Eighth Street
Oakland, CA 94606
(510) 466-7229

Legal process may be served upon the *plan administrator*.

Union Plans:

This *Plan* is established in accordance with a collective bargaining agreement for the Peralta Federation of Teachers, the Service Employees International Union, Local 1021 or the International Union of Operating Engineers, Local 39, AFL-CIO. *Employees* have a right to obtain a copy of the collective bargaining agreement. A written request for such copy should be submitted to the *plan administrator*. The collective bargaining agreement is available in the *plan administrator's* office.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the *Plan*, refer to the following section:

Eligibility, Enrollment and Effective Date

For detailed information regarding a person being ineligible for benefits through reaching *maximum benefit* levels, termination of coverage or *Plan* exclusions, refer to the following sections:

Schedule of Benefits
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for *Plan* expenses are obtained from the *employer* and from covered *employees*. The *employer* evaluates the costs of the *Plan* based on projected *Plan* expenses and determines the amount to be contributed by the *employer* and the amount to be contributed by the covered *employees*. Contributions by the covered *employees* are deducted from their pay on a pre-tax basis as authorized by the *employee* on the enrollment form (whether paper or electronic) or other applicable forms.

Funding Method:

The *employer* pays *Plan* benefits and administration expenses directly from general assets. Contributions received from *covered persons* are used to cover *Plan* costs and are expended immediately.

Ending Date of Plan Year:

June 30th

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled *Claim Filing Procedure*.

The designated *claims processor* for claims is:

CoreSource, Inc.
PO Box 2920
Clinton, IA 52733-2920

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the **Plan's** benefits, refer to the following sections: *Claim Filing Procedure, Medical Expense Benefit, Medical Exclusions, Prescription Drug Program, Vision Expense Benefit, Plan Exclusions and Preferred Provider or Nonpreferred Provider.*

*Medical Benefits –
Union #1021 Managers, Confidants and PFT PPO Traditional Plan:*

UNION #1021 PPO TRADITIONAL PLAN

Maximum Benefit Per Covered Person While Covered By This Plan For:	Unlimited	
<i>Essential Health Benefits</i> for Medical		
<p>Notwithstanding any provision of the Plan to the contrary, all benefits received by an individual under any benefit option, package or coverage under the Plan shall be applied toward any applicable Essential Health Benefits/non-Essential Health Benefits maximum benefit paid by the Plan for any one covered person for such option, package or coverage under the Plan, and also toward any applicable Essential Health Benefits/non-Essential Health Benefits maximum benefit under any other options, packages or coverages under the Plan in which the individual may participate in the future.</p>		
	<i>Preferred Provider</i>	<i>Nonpreferred Provider</i>
Deductible Per Calendar Year:		
Individual (Per Person)	\$100	\$100
Family (3 individuals)	\$300	\$300
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)		
Individual (Per Person)	\$300	\$1,000
Family (3 individuals)	\$900	\$3,000
<p>Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> for a listing of charges not applicable to the out-of-pocket expense limit.</p> <p>Amounts applied toward satisfaction of the preferred provider deductible and out-of-pocket expense limit may also be applied toward satisfaction of the nonpreferred provider deductible and out-of-pocket expense limit and vice versa.</p>		
Coinsurance:		
<p>The Plan pays the percentage listed on the following pages for covered expenses incurred by a covered person during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays one hundred percent (100%) of covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i>, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.</p>		

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Inpatient Hospital		
Inpatient Expenses	100%	80%
Professional Charges (includes <i>physician</i> , assistant surgeon, anesthesiologist, pathologist, radiologist)	100%	80%
Surgery Expenses		
Surgeon's fees (<i>inpatient</i> and <i>outpatient</i>)	100%	80%
Second Opinion Consultation	100%	80%
Emergency Room Services (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> no deductible 100%	\$35 <i>copay</i> no deductible 100%
Non- <i>Emergency</i> Care (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> 80%	\$35 <i>copay</i> 80%
Office Visit		
<i>Illness</i> or <i>Injury</i> (<i>Copay</i> applies to all services performed during office visit)	\$10 <i>copay</i> no deductible 100%	80%
Diagnostic Services and Supplies	100%	80%
Extended Care Facility Limitation: 100 days <i>maximum benefit</i> per <i>confinement</i>	100%	80%
Home Health Care Limitation: 100 visits <i>maximum benefit</i> per calendar year	100%	80%
Hospice Care	100%	80%
Durable Medical Equipment	100%	80%
Ambulance Expenses	100% no deductible	100% no deductible
Well Child Care - Birth through age eighteen (18)	100% no deductible	No coverage

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Routine Preventive Care - Age nineteen (19) and over		
Routine Examination Only	100% no deductible	80%
Routine Mammogram Limitation: One (1) mammogram <i>maximum benefit</i> per calendar year for women age thirty-five (35) and over	100% no deductible	80%
Routine Gynecological Exam & Pap Smear Limitation: One (1) gynecological exam & pap smear <i>maximum benefit</i> per calendar year	100% no deductible	80%
Routine Prostate Specific Antigen (PSA) Test Limitation: One (1) PSA test <i>maximum benefit</i> per calendar year for men age forty (40) and over	100% no deductible	80%
All Other Wellness Benefits, including immunizations	100% no deductible	80%
Women's Preventive Services	100% no deductible	80%
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	100%	80%
Outpatient Clinic/Office Visit	\$10 <i>copay</i> no deductible 100%	80%
Other Outpatient Services	100%	80%
Therapy Services (Physical, Speech, Occupational, Diabetic Education, Nutrition, and other <i>medically necessary</i> therapies)	100%	80%
Hearing Aid Expenses Limitation: \$5,000 <i>maximum benefit</i> per five (5) year period	50%	50%
Infertility Diagnosis & Treatment Limitation: \$5,000 <i>maximum benefit</i> for non- <i>essential health benefits</i> while covered by this <i>Plan</i>	100%	80%
Foot Orthotics Limitation: \$2,000 <i>maximum benefit</i> per calendar year	100%	80%
Prostheses	100%	80%
All Other Covered Expenses	100%	80%

Refer to *Medical Expense Benefit* for complete details.

*Medical Benefits –
Union #1021 Managers, Confidants and PFT PPO Lite Plan:*

UNION #1021 PPO LITE PLAN

Maximum Benefit Per Covered Person While Covered By This Plan For: <i>Essential Health Benefits</i> for Medical	Unlimited
Notwithstanding any provision of the <i>Plan</i> to the contrary, all benefits received by an individual under any benefit option, package or coverage under the <i>Plan</i> shall be applied toward any applicable <i>Essential Health Benefits/non-Essential Health Benefits maximum benefit</i> paid by the <i>Plan</i> for any one <i>covered person</i> for such option, package or coverage under the <i>Plan</i> , and also toward any applicable <i>Essential Health Benefits/non-Essential Health Benefits maximum benefit</i> under any other options, packages or coverages under the <i>Plan</i> in which the individual may participate in the future.	
Deductible Per Calendar Year:	
Individual (Per Person)	\$100
Family (3 individuals)	\$300
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	
Individual (Per Person)	\$300
Family (3 individuals)	\$900
Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> for a listing of charges not applicable to the out-of-pocket expense limit.	
Coinsurance:	
The <i>Plan</i> pays the percentage listed on the following pages for <i>covered expenses incurred</i> by a <i>covered person</i> during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the <i>Plan</i> pays one hundred percent (100%) of <i>covered expenses</i> for the remainder of the calendar year or until the <i>maximum benefit</i> has been reached. Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> , for a listing of charges not applicable to the one hundred percent (100%) <i>coinsurance</i> .	

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Inpatient Hospital		
Inpatient Expenses	100%	No Coverage
Professional Charges (includes <i>physician</i> , assistant surgeon, anesthesiologist, pathologist, radiologist)	100%	No Coverage
Surgery Expenses		
Surgeon's fees (<i>inpatient</i> and <i>outpatient</i>)	100%	No Coverage
Second Opinion Consultation	100%	No Coverage
Emergency Room Services (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> no deductible 100%	\$35 <i>copay</i> no deductible 100%
Non- <i>Emergency</i> Care (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> 80%	No Coverage
Office Visit		
<i>Illness</i> or <i>Injury</i> (<i>Copay</i> applies to all services performed during office visit)	\$10 <i>copay</i> no deductible 100%	No Coverage
Diagnostic Services and Supplies	100%	No Coverage
Extended Care Facility Limitation: 100 days <i>maximum benefit</i> per <i>confinement</i>	100%	No Coverage
Home Health Care Limitation: 100 visits <i>maximum benefit</i> per calendar year	100%	No Coverage
Hospice Care	100%	No Coverage
Durable Medical Equipment	100%	No Coverage
Ambulance Expenses	100% no deductible	100% no deductible
Well Child Care - Birth through age eighteen (18)	100% no deductible	No Coverage

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Routine Preventive Care - Age nineteen (19) and over Routine Examination Only Routine Mammogram Limitation: One (1) mammogram <i>maximum benefit</i> per calendar year for women age thirty-five (35) and over Routine Gynecological Exam & Pap Smear Limitation: One (1) gynecological exam & pap smear <i>maximum benefit</i> per calendar year Routine Prostate Specific Antigen (PSA) Test Limitation: One (1) PSA test <i>maximum benefit</i> per calendar year for men age forty (40) and over All Other Wellness Benefits, including immunizations	100% no deductible 100% no deductible 100% no deductible 100% no deductible 100% no deductible	No Coverage No Coverage No Coverage No Coverage No Coverage
Women's Preventive Services	100% no deductible	No Coverage
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	100%	No Coverage
Outpatient Clinic/Office Visit	\$10 <i>copay</i> no deductible 100%	No Coverage
Other Outpatient Services	100%	No Coverage
Therapy Services (Physical, Speech, Occupational, Diabetic Education, Nutrition, and other <i>medically necessary</i> therapies)	100%	No Coverage
Hearing Aid Expenses Limitation: \$5,000 <i>maximum benefit</i> per five (5) year period	50%	No Coverage
Infertility Diagnosis & Treatment Limitation: \$5,000 <i>maximum benefit</i> for non-essential health benefits while covered by this <i>Plan</i>	100%	No Coverage
Foot Orthotics Limitation: \$2,000 <i>maximum benefit</i> per calendar year	100%	No Coverage
Prostheses	100%	No Coverage
All Other Covered Expenses	100%	No Coverage

Refer to *Medical Expense Benefit* for complete details.

*Medical Benefits –
Union #39 PPO Traditional Plan:*

UNION #39 PPO TRADITIONAL PLAN

Maximum Benefit Per Covered Person While Covered By This Plan For:		
<i>Essential Health Benefits</i> for Medical	Unlimited	
Notwithstanding any provision of the <i>Plan</i> to the contrary, all benefits received by an individual under any benefit option, package or coverage under the <i>Plan</i> shall be applied toward any applicable <i>Essential Health Benefits/non-Essential Health Benefits maximum benefit</i> paid by the <i>Plan</i> for any one <i>covered person</i> for such option, package or coverage under the <i>Plan</i> , and also toward any applicable <i>Essential Health Benefits/non-Essential Health Benefits maximum benefit</i> under any other options, packages or coverages under the <i>Plan</i> in which the individual may participate in the future.		
	<i>Preferred Provider</i>	<i>Nonpreferred Provider</i>
Deductible Per Calendar Year:		
Individual (Per Person)	\$100	\$100
Family (3 individuals)	\$300	\$300
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)		
Individual (Per Person)	\$300	\$1,000
Family (3 individuals)	\$900	\$3,000
Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> for a listing of charges not applicable to the out-of-pocket expense limit.		
Amounts applied toward satisfaction of the <i>preferred provider</i> deductible and out-of-pocket expense limit may also be applied toward satisfaction of the <i>nonpreferred provider</i> deductible and out-of-pocket expense limit and vice versa.		
Coinsurance:		
The <i>Plan</i> pays the percentage listed on the following pages for <i>covered expenses incurred</i> by a <i>covered person</i> during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the <i>Plan</i> pays one hundred percent (100%) of <i>covered expenses</i> for the remainder of the calendar year or until the <i>maximum benefit</i> has been reached. Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> , for a listing of charges not applicable to the one hundred percent (100%) <i>coinsurance</i> .		

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Inpatient Hospital		
Inpatient Expenses	100%	80%
Professional Charges (includes <i>physician</i> , assistant surgeon, anesthesiologist, pathologist, radiologist)	100%	80%
Surgery Expenses		
Surgeon's fees (<i>inpatient</i> and <i>outpatient</i>)	100%	80%
Second Opinion Consultation	100%	80%
Emergency Room Services (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> no deductible 100%	\$35 <i>copay</i> no deductible 100%
Non- <i>Emergency</i> Care (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> 80%	\$35 <i>copay</i> 80%
Office Visit		
<i>Illness</i> or <i>Injury</i> (<i>Copay</i> applies to all services performed during office visit)	\$15 <i>copay</i> no deductible 100%	80%
Diagnostic Services and Supplies	100%	80%
Extended Care Facility Limitation: 100 days <i>maximum benefit</i> per <i>confinement</i>	100%	80%
Home Health Care Limitation: 100 visits <i>maximum benefit</i> per calendar year	100%	80%
Hospice Care	100%	80%
Durable Medical Equipment	100%	80%
Ambulance Expenses	100% no deductible	100% no deductible
Well Child Care - Birth through age eighteen (18)	100% no deductible	No coverage

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Routine Preventive Care - Age nineteen (19) and over Routine Examination Only Routine Mammogram Limitation: One (1) mammogram <i>maximum benefit</i> per calendar year for women age thirty-five (35) and over Routine Gynecological Exam & Pap Smear Limitation: One (1) gynecological exam & pap smear <i>maximum benefit</i> per calendar year Routine Prostate Specific Antigen (PSA) Test Limitation: One (1) PSA test <i>maximum benefit</i> per calendar year for men age forty (40) and over All Other Wellness Benefits, including immunizations	100% no deductible 100% no deductible 100% no deductible 100% no deductible 100% no deductible	80% 80% 80% 80% 80%
Women's Preventive Services	100% no deductible	80%
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	100%	80%
Outpatient Clinic/Office Visit	\$15 <i>copay</i> no deductible 100%	80%
Other Outpatient Services	100%	80%
Therapy Services (Physical, Speech, Occupational, Diabetic Education, Nutrition, and other <i>medically necessary</i> therapies)	100%	80%
Hearing Aid Expenses Limitation: \$5,000 <i>maximum benefit</i> per five (5) year period	50%	50%
Infertility Diagnosis & Treatment Limitation: \$5,000 <i>maximum benefit</i> for non- <i>essential health benefits</i> while covered by this <i>Plan</i>	100%	80%
Foot Orthotics Limitation: \$2,000 <i>maximum benefit</i> per calendar year	100%	80%
Prostheses	100%	80%
All Other Covered Expenses	100%	80%

Refer to *Medical Expense Benefit* for complete details.

*Medical Benefits –
Union #39 PPO Lite Plan:*

UNION #39 PPO LITE PLAN

<p>Maximum Benefit Per Covered Person While Covered By This Plan For:</p> <p><i>Essential Health Benefits</i> for Medical</p>	<p>Unlimited</p>
<p>Notwithstanding any provision of the <i>Plan</i> to the contrary, all benefits received by an individual under any benefit option, package or coverage under the <i>Plan</i> shall be applied toward any applicable <i>Essential Health Benefits/non-Essential Health Benefits maximum benefit</i> paid by the <i>Plan</i> for any one <i>covered person</i> for such option, package or coverage under the <i>Plan</i>, and also toward any applicable <i>Essential Health Benefits/non-Essential Health Benefits maximum benefit</i> under any other options, packages or coverages under the <i>Plan</i> in which the individual may participate in the future.</p>	
<p>Deductible Per Calendar Year:</p> <p>Individual (Per Person)</p> <p>Family (3 individuals)</p>	<p>\$100</p> <p>\$300</p>
<p>Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)</p> <p>Individual (Per Person)</p> <p>Family (3 individuals)</p>	<p>\$300</p> <p>\$900</p>
<p>Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> for a listing of charges not applicable to the out-of-pocket expense limit.</p> <p>Amounts applied toward satisfaction of the <i>preferred provider</i> deductible and out-of-pocket expense limit may also be applied toward satisfaction of the <i>nonpreferred provider</i> deductible and out-of-pocket expense limit and vice versa.</p>	
<p>Coinsurance:</p> <p>The <i>Plan</i> pays the percentage listed on the following pages for <i>covered expenses incurred</i> by a <i>covered person</i> during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the <i>Plan</i> pays one hundred percent (100%) of <i>covered expenses</i> for the remainder of the calendar year or until the <i>maximum benefit</i> has been reached. Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i>, for a listing of charges not applicable to the one hundred percent (100%) <i>coinsurance</i>.</p>	

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Inpatient Hospital		
Inpatient Expenses	100%	No Coverage
Professional Charges (includes <i>physician</i> , assistant surgeon, anesthesiologist, pathologist, radiologist)	100%	No Coverage
Surgery Expenses		
Surgeon's fees (<i>inpatient</i> and <i>outpatient</i>)	100%	No Coverage
Second Opinion Consultation	100%	No Coverage
Emergency Room Services (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> no deductible 100%	\$35 <i>copay</i> no deductible 100%
Non- <i>Emergency</i> Care (<i>Copay</i> waived if admitted)	\$35 <i>copay</i> 80%	No Coverage
Office Visit		
<i>Illness</i> or <i>Injury</i> (<i>Copay</i> applies to all services performed during office visit)	\$15 <i>copay</i> no deductible 100%	No Coverage
Diagnostic Services and Supplies	100%	No Coverage
Extended Care Facility Limitation: 100 days <i>maximum benefit</i> per <i>confinement</i>	100%	No Coverage
Home Health Care Limitation: 100 visits <i>maximum benefit</i> per calendar year	100%	No Coverage
Hospice Care	100%	No Coverage
Durable Medical Equipment	100%	No Coverage
Ambulance Expenses	100% no deductible	100% no deductible
Well Child Care - Birth through age eighteen (18)	100% no deductible	No coverage

BENEFIT DESCRIPTION Plan deductible will apply unless otherwise noted	Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>)	Nonpreferred Provider (% of <i>customary and reasonable amount</i>)
Routine Preventive Care - Age nineteen (19) and over Routine Examination Only Routine Mammogram Limitation: One (1) mammogram <i>maximum benefit</i> per calendar year for women age thirty-five (35) and over Routine Gynecological Exam & Pap Smear Limitation: One (1) gynecological exam & pap smear <i>maximum benefit</i> per calendar year Routine Prostate Specific Antigen (PSA) Test Limitation: One (1) PSA test <i>maximum benefit</i> per calendar year for men age forty (40) and over All Other Wellness Benefits, including immunizations	100% no deductible 100% no deductible 100% no deductible 100% no deductible 100% no deductible	No Coverage No Coverage No Coverage No Coverage No Coverage
Women's Preventive Services	100% no deductible	No Coverage
Mental & Nervous Disorders and Chemical Dependency Care		
Inpatient Services	100%	No Coverage
Outpatient Clinic/Office Visit	\$15 <i>copay</i> no deductible 100%	No Coverage
Other Outpatient Services	100%	No Coverage
Therapy Services (Physical, Speech, Occupational, Diabetic Education, Nutrition, and other <i>medically necessary</i> therapies)	100%	No Coverage
Hearing Aid Expenses Limitation: \$5,000 <i>maximum benefit</i> per five (5) year period	50%	No Coverage
Infertility Diagnosis & Treatment Limitation: \$5,000 <i>maximum benefit</i> for non- <i>essential health benefits</i> while covered by this <i>Plan</i>	100%	No Coverage
Foot Orthotics Limitation: \$2,000 <i>maximum benefit</i> per calendar year	100%	No Coverage
Prostheses	100%	No Coverage
All Other Covered Expenses	100%	No Coverage

Refer to *Medical Expense Benefit* for complete details.

Centers of Excellence Program –
PPO Traditional Plan:

PPO TRADITIONAL PLAN

Centers of Excellence Program (Transplants)	<i>Procedures done at a DESIGNATED Centers of Excellence facility</i>	<i>Procedures done at a NON- DESIGNATED Centers of Excellence facility</i>
Maximum Benefit Per Transplant For Travel, Meals & Lodging:	\$10,000	Not Covered
Transplant Procedure Expenses		
Travel, lodging and meals	100% no deductible	Not Covered
All other covered Transplant expenses	100%	<i>Preferred Provider</i> 100% <i>Nonpreferred Provider</i> 80%

Centers of Excellence Program –
PPO Lite Plan:

PPO LITE PLAN

Centers of Excellence Program (Transplants)	<i>Procedures done at a DESIGNATED Centers of Excellence facility</i>	<i>Procedures done at a NON- DESIGNATED Centers of Excellence facility</i>
Maximum Benefit Per Transplant For Travel, Meals & Lodging:	\$10,000	No Coverage
Transplant Procedure Expenses		
Travel, lodging and meals	100% no deductible	No Coverage
All other covered Transplant expenses	100%	<i>Preferred Provider</i> 100% <i>Nonpreferred Provider</i> No Coverage

Prescription Drug Program – Union #39 PPO Traditional & Lite Plans:

Pharmacy Option

Prescription Drug Card 100% after *copay*
Copay Generic: \$10 *copay*
Brand Name: \$20 *copay**

Limitation: 30 day supply

*If no generic equivalent, the generic *copay* will apply.

Mail Order Option

Mail Order Prescription 100% after *copay*
Copay Generic: \$20 *copay*
Brand Name: \$30 *copay*

Limitation: 90 day supply

Prescription Drug Program – All Other Plans:

Pharmacy Option

Prescription Drug Card 100% after *copay*
Copay Generic: \$10 *copay*
Brand Name: \$15 *copay**

Limitation: 30 day supply

*If no generic equivalent, the generic *copay* will apply.

Mail Order Option

Mail Order Prescription 100% after *copay*
Copay Generic: \$5 *copay*
Brand Name: \$5 *copay*

Limitation: 90 day supply

Refer to *Prescription Drug Program* for complete details.

UHC Vision Benefits – Union #39 PPO Traditional & Lite Plans:

Frequency of Benefits

Examination: After the examination *copay* of \$15, a comprehensive vision examination is covered once every twelve (12) consecutive month period. *Copays* are not applicable to *nonpreferred providers*.

Lenses/Frames (materials): After the materials *copay* of \$0, standard lenses and frames are covered once every twelve (12) consecutive month period.*

*Note: Contact lenses will be in lieu of lenses and frames benefit.

Benefit Description	Preferred Provider	Non-Preferred Provider
Exams Optometrist Exam Ophthalmologist Exam	100% 100%	Up to a \$40 allowance Up to a \$40 allowance
Lenses Single Vision Bifocal Trifocal Lenticular	100% 100% 100% 100%	Up to a \$40 allowance Up to a \$40 allowance Up to a \$40 allowance Up to a \$40 allowance
Frames	100% ⁽¹⁾	Up to a \$40 allowance
Contact Lenses (in lieu of lenses and frames benefit) Cosmetic Medically Necessary ⁽²⁾	100% ⁽⁴⁾ 100% ⁽⁴⁾	Up to a \$150 allowance ⁽³⁾ Up to a \$210 allowance

¹⁾ If you select a frame outside of UHC's covered-in-full selection, you will receive a \$50 wholesale frame allowance at private practice providers, or a minimum \$120 retail frame allowance at retail chain providers.

²⁾ Medically necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following cataract surgery; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; or with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UHC concerning the reimbursement that UHC will make before you purchase the contacts.

³⁾ Less any network fitting/evaluation fee.

⁴⁾ If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC's covered contact lenses may vary by provider. Should you choose contact lenses outside of the covered selection, a \$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses. Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full.

UHC Vision Benefits – All Other Traditional & Lite Plans:

Frequency of Benefits

Examination: After the examination *copay* of \$10, a comprehensive vision examination is covered once every twelve (12) consecutive month period. *Copays* are not applicable to *nonpreferred providers*.

Lenses/Frames (materials): After the materials *copay* of \$0, standard lenses and frames are covered once every twelve (12) consecutive month period.*

*Note: Contact lenses will be in lieu of lenses and frames benefit.

Benefit Description	Preferred Provider	Non-Preferred Provider
Exams Optometrist Exam Ophthalmologist Exam	100% 100%	Up to a \$40 allowance Up to a \$40 allowance
Lenses Single Vision Bifocal Trifocal Lenticular	100% 100% 100% 100%	Up to a \$40 allowance Up to a \$40 allowance Up to a \$40 allowance Up to a \$40 allowance
Frames	100% ⁽¹⁾	Up to a \$40 allowance
Contact Lenses (in lieu of lenses and frames benefit) Cosmetic Medically Necessary ⁽²⁾	100% ⁽⁴⁾ 100% ⁽⁴⁾	Up to a \$150 allowance ⁽³⁾ Up to a \$210 allowance

¹⁾ If you select a frame outside of UHC's covered-in-full selection, you will receive a \$50 wholesale frame allowance at private practice providers, or a minimum \$120 retail frame allowance at retail chain providers.

²⁾ Medically necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following cataract surgery; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; or with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UHC concerning the reimbursement that UHC will make before you purchase the contacts.

³⁾ Less any network fitting/evaluation fee.

⁴⁾ If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC's covered contact lenses may vary by provider. Should you choose contact lenses outside of the covered selection, a \$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses. Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full.

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a *preferred provider* or a *nonpreferred provider*.

PREFERRED PROVIDER

Anthem BC Prudent Buyer Plan Preferred Provider (California Residents)

An *Anthem BC Prudent Buyer Plan Preferred Provider* is a *physician, hospital* or ancillary service provider which has an agreement in effect with BC Life & Health Insurance Company to accept a *negotiated rate* for services rendered to *covered persons*. The *Anthem BC Prudent Buyer Plan Preferred Provider* cannot bill the *covered person* for any amount in excess of the *negotiated rate*. *Covered persons* should contact the *employer's* Human Resources Department for a current listing of *Anthem BC Prudent Buyer Plan Preferred Providers*.

The *Anthem BC Prudent Buyer Plan negotiated rate* is only available for medical services, treatment or supplies that are a *covered expense* under this *Plan*.

Out-of-Area Services

Anthem is able to leverage other Blue Plan contracts with providers when services are accessed outside of Anthem's service area. The claims for these services are processed through "Inter-Plan Programs", which follow specific processing rules required by the Blue Cross and Blue Shield Association (BCBSA). These could include the BlueCard Program, Negotiated National Account Arrangements ("Negotiated Arrangements"), or special arrangements for processing claims from non-network (non-participating) providers.

BlueCard Program

When claims occur outside of the state providing the account's policy Anthem is still responsible for ensuring claims process according to the client's benefit. When claims occur in another Blue Plans service area, the local Blue Plan is responsible for all interactions with that local provider. For example, Anthem pays the local Blue Plan for the benefit paid on the claim and they cut the check to their provider.

Host Blue Plans may use various methods to determine a negotiated price with a provider, including the use of incentive programs. The following are methods that Host Plans may use to calculate negotiated prices for Blue members:

1. *Actual Price* Host Blue Plan passes the specific negotiated price as stated within the provider's contract for a specific service.
2. *Estimated/Average Price*: Host Blue Plan passes a percent of billed charges based on an estimated/average amount they expect to pay on claims and non-claim-related transactions for a provider. For example, the estimated/average price takes into consideration provider incentive programs, like pay for performance. The estimated/average amount passed on the claim includes the anticipated settlement that will be paid to the provider. Refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses, etc.
3. *Average Price*: Host Blue Plan passes a percent of billed charges based on an average amount they expect to save with a specific group of providers. The Host Blue Plan percentage amount takes into account any settlements, withholds or any other contingent payment arrangements. These transactions may include the ones noted above for estimated price.

Host Blue Plans that use estimated or average price are allowed to increase or decrease future claim allowance prices based on previous claim experience. For example, a current price may have been decreased due to credits on claims already paid to a provider. A Host Plan may never adjust the price on claims that have already been processed in the system. In other words, the price a Host Blue Plan passes to Anthem is the final price and cannot be adjusted based on pricing of past claims.

If a Host Blue Plan uses estimated or average price on a claim they may hold a portion of the amount paid in a variance account. This money eventually is put towards a provider settlement and/or goes towards future adjustment to negotiated prices.

A small number of states require that Host Blue Plans charge a surcharge which is payable to the state. This requires that Host Blue Plans do not reflect the entire savings on covered services or add a surcharge. In this situation Anthem would calculate member and client liability in accordance with the applicable law.

Negotiated National Account Arrangements:

When it is advantageous to the client, Anthem may agree on a custom provider network with a Host Blue Plan. When an arrangement is not standard (use of a different network – altnet) it is referred to as a negotiated national account arrangement. A National Account in this context means that the employer has employees residing in more than one state. When there is custom arrangement in place the same rules as the standard arrangements apply to the processing of claims.

Non-Network Providers Outside Anthem's Service Area:

Host Blue Plans pass pricing on claims for non-contracted providers. The pricing is either the same as what they would use for their own local member claims or the pricing arrangements required by state law. In either situation the member is responsible for the difference between the charge on the claim and the pricing sent by the Host Blue Plan.

Exceptions may be made to process a claim as in-network when there is no contracted provider of that type available within a reasonable distance of their residence. As long as the Host Blue Plan approves, Anthem may try and negotiate a lower price with the non-contracted provider.

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider covered expenses***. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person***.

Covered expenses for emergency services by a ***nonpreferred provider*** shall be paid at the greatest of the following three amounts: the amount negotiated with ***preferred providers*** for such ***covered expenses***, the amount determined as the ***customary and reasonable amount***, or the amount that would be paid under ***Medicare*** for such ***emergency services***.

CONTINUITY OF CARE

In the event that a ***covered person*** was receiving services from a provider of service that is not in the ***preferred provider network*** on the date in which the ***preferred provider network*** was integrated into this ***Plan***, then the charges resulting from services rendered by the provider will be deemed as having been rendered by a ***preferred provider*** until the earlier of: the date treatment is concluded (or diagnosis changes), or the end of one month from the date of network integration or change.

If a **covered person** is receiving services for maternity care from a **preferred provider** that is not in the **preferred provider network** on the date that the network was integrated into this **Plan**, the charges resulting from services rendered by that provider will be deemed as having been rendered by a **preferred provider** until the date treatment is concluded.

REFERRALS

Referrals to a **nonpreferred provider** are covered as **nonpreferred provider** services, supplies and treatments. It is the responsibility of the **covered person** to assure services to be rendered are performed by **preferred providers** in order to receive the **preferred provider** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a **nonpreferred provider** where **covered expenses** shall be payable at the **preferred provider** level of benefits:

1. **Emergency services** by a **nonpreferred provider** in the emergency department of a **hospital**. If the **covered person** is admitted to the **hospital** on an **emergency** basis, **covered expenses** shall be payable at the **preferred provider** level.
2. **Nonpreferred** anesthesiologist when the operating surgeon is a **preferred provider** and/or the **facility** where such services are rendered is a **preferred provider**.
3. **Nonpreferred** assistant surgeon if the operating surgeon is a **preferred provider**.
4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a **nonpreferred provider** when the **facility** where such services are rendered is a **preferred provider**.
5. Diagnostic laboratory and surgical pathology tests referred to a **nonpreferred provider** by a **preferred provider**.
6. While the **covered person** is confined to a **preferred provider hospital**, the **preferred provider physician** requests a consultation from a **nonpreferred provider**, or a newborn visit is performed by a **nonpreferred provider**.
7. **Medically necessary** specialty services, supplies or treatments that are not available from a provider within the **Preferred Provider Organization**.
8. **PPO Traditional Plan - Union #1021 & Union #39:**
When a covered **dependent** resides outside the service area of the **Preferred Provider Organization**, for example a full-time student or due to a divorce situation, treatment or services will be paid at the **preferred provider** rate.
9. **Covered persons** who do not have access to **preferred providers** within thirty (30) miles of their place of residence, or for emergency treatment rendered while traveling out of area.
10. Treatment rendered at a **facility** of the uniformed services or Indian Health Care **facility**.

MEDICAL EXPENSE BENEFIT

This section describes the *covered expenses* of the *Plan*. All *covered expenses* are subject to applicable *Plan* provisions including, but not limited to: deductible, *copay*, *coinsurance* and *maximum benefit* provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense *incurred* by the *covered person* for services, supplies or treatment that is greater than the *customary and reasonable amount* for *nonpreferred providers* or *negotiated rate* for *preferred providers* will not be considered a *covered expense* by this *Plan*. Specified preventive care expenses will be considered to be *covered expenses*.

COPAY

The *copay* is the amount payable by the *covered person* for certain services, supplies or treatment rendered by a *professional provider*. The service and applicable *copay* are shown on the *Schedule of Benefits*. The *covered person* selects a *professional provider* and pays the applicable *copay*. The *Plan* pays the remaining *covered expenses* at the *negotiated rate* for *preferred providers* or the *customary and reasonable amount* for *nonpreferred providers*. The *copay* must be paid each time a treatment or service is rendered.

The *copay* will not be applied toward the following:

1. The calendar year deductible.
2. The deductible carry-over.

DEDUCTIBLES

Individual Deductible

The individual deductible is the dollar amount of *covered expense* which each *covered person* must have *incurred* during each calendar year before the *Plan* pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

When three (3) covered members of the same family have each met their individual deductible amount during a calendar year, the family deductible amount shall be considered satisfied for that calendar year and no further deductible amount shall be taken from the expenses of any covered family member for the remainder of that calendar year.

Deductible Carry-Over

Amounts *incurred* during October, November and December and applied toward the deductible of any *covered person*, will also be applied to the deductible of that *covered person* in the next calendar year.

COINSURANCE

The *Plan* pays a specified percentage of *covered expenses* at the *customary and reasonable amount* for *nonpreferred providers*, or the percentage of the *negotiated rate* for *preferred providers*. That percentage is specified on the *Schedule of Benefits*. For *nonpreferred providers*, the *covered person* is responsible for the difference between the percentage the *Plan* paid and one hundred percent (100%) of the billed amount. The *covered person's* portion of the *coinsurance* represents the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the **covered person** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for **covered expenses**, the **Plan** will begin to pay one hundred percent (100%) of **covered expenses** for the remainder of the calendar year.

After three (3) covered family members have each **incurred** an amount equal to the individual out-of-pocket expense limit listed on the *Schedule of Benefits*, the **Plan** will pay one hundred percent (100%) of **covered expenses** for all covered family members for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by this **Plan**, to include charges in excess of the **customary and reasonable amount** or **negotiated rate**, as applicable.
2. Expenses **incurred** as a result of failure to obtain pre-certification.

MAXIMUM BENEFIT

The **maximum benefit** payable on behalf of a **covered person** is shown on the *Schedule of Benefits*. The **maximum benefit** applies to the entire time the **covered person** is covered under the **Plan**, either as an **employee, dependent, alternate recipient** or under COBRA. If the **covered person's** coverage under the **Plan** terminates and at a later date he again becomes covered under the **Plan**, the **maximum benefit** will include all benefits paid by the **Plan** for the **covered person** during any period of coverage.

The *Schedule of Benefits* may contain separate **maximum benefit** limitations for specified conditions and/or services. Any separate **maximum benefit** will include all such benefits paid by the **Plan** for the **covered person** during any and all periods of coverage under this **Plan**. All separate **maximum benefits** are part of, and not in addition to, the **maximum benefit**. No more than the **maximum benefit** will be paid for any **covered person** while covered by this **Plan**.

Notwithstanding any provision of the **Plan** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the **Plan** shall be applied toward any applicable **Essential Health Benefits/non-Essential Health Benefits maximum benefit** paid by the **Plan** for any one **covered person** for such option, package or coverage under the **Plan**, and also toward any applicable **Essential Health Benefits/non-Essential Health Benefits maximum benefit** under any other options, packages or coverages under the **Plan** in which the individual may participate in the future.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits as specified in the *Claim Filing Procedure* section of this document.

Covered expenses shall include:

1. **Room and board** for treatment in a **hospital**, including **intensive care units**, cardiac care units and similar **medically necessary** accommodations. **Covered expenses** for **room and board** shall be limited to the **hospital's semiprivate** rate. **Covered expenses** for **intensive care** or cardiac care units shall be the **customary and reasonable amount** for **nonpreferred providers** and the percentage of the **negotiated rate** for **preferred providers**. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the **covered person**.

2. Miscellaneous **hospital** services, supplies, and treatments including, but not limited to:
 - a. Admission fees, and other fees assessed by the **hospital** for rendering services, supplies and treatments;
 - b. Use of operating, treatment or delivery rooms;
 - c. Anesthesia, anesthesia supplies and its administration by an employee of the **hospital**;
 - d. Medical and surgical dressings and supplies, casts and splints;
 - e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
 - f. Drugs and medicines (except drugs not used or consumed in the **hospital**);
 - g. X-ray and diagnostic laboratory procedures and services;
 - h. Oxygen and other gas therapy and the administration thereof;
 - i. Therapy services.
3. Services, supplies and treatments described above furnished by an **ambulatory surgical facility**, including follow-up care provided within seventy-two (72) hours of a procedure.
4. Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a **hospital** admission which are related to the condition which is necessitating the **confinement**. Such tests shall be payable even if they result in additional medical treatment prior to **confinement** or if they show that **hospital confinement** is not **medically necessary**. Such tests shall not be payable if the same tests are performed again after the **covered person** has been admitted.

FACILITY PROVIDERS

Services provided by a **facility** provider are covered if such services would have been covered if performed in a **hospital** or **ambulatory surgical facility**.

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the **covered person** from the place of **injury** or serious medical incident to the nearest **hospital** where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the **covered person** to or from a **hospital** or between **hospitals** for required treatment when such transportation is certified by the attending **physician** as **medically necessary**. Such transportation is covered only from the initial **hospital** to the nearest **hospital** qualified to render the special treatment.
3. **Emergency** services actually provided by an advance life support unit, even though the unit does not provide transportation.

EMERGENCY ROOM SERVICES

Covered expenses for **emergency services** in the emergency department of a **hospital** shall be paid in accordance with the *Schedule of Benefits*, provided the condition meets the definition of **emergency** herein. **Emergency services** by a **nonpreferred provider** shall be paid as specified in the section, *Preferred Provider or Nonpreferred Provider* under the subsection, *Nonpreferred Provider*.

Emergency room treatment for conditions that do not meet the definition of **emergency** will be considered non-**emergency** use of the emergency room and will be subject to the **coinsurance** as shown on the *Schedule of Benefits*.

Emergency medical or **accident** care must begin within seventy-two (72) hours of the **injury** or the onset of the **emergency**.

The emergency room **copay** shall be waived if the patient is admitted directly into the **hospital**.

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

Covered expenses shall include the following services when performed by a **physician** or a **professional provider**:

1. Medical treatment, services and supplies including, but not limited to: office visits, **inpatient** visits, home visits.
2. Surgical treatment. Separate payment will not be made for **inpatient** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, **covered expenses** shall include the surgical allowance for the highest paying procedure, and fifty percent (50%) of the surgical allowance for each additional procedure.

When two (2) or more unrelated operations or procedures are performed at the same operative session, **covered expenses** shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a **physician** or **professional provider** if it is determined that the condition of the **covered person** or the type of surgical procedure requires such assistance. **Covered expenses** for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.
4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.
5. Consultations requested by the attending **physician** during a **hospital confinement**. Consultations do not include staff consultations that are required by a **hospital's** rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the **physician**.

The **physician** rendering the second opinion regarding the **medical necessity** of such surgery must be a board certified specialist in the treatment of the **covered person's illness** or **injury** and must not be affiliated in any way with the **physician** who will be performing the actual surgery.

In the event of conflicting opinions, a third opinion may be obtained. The **Plan** will consider payment for a third opinion the same as a second surgical opinion.

The second surgical opinion benefit includes **physician** services and any diagnostic services as may be required.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

TRANSPLANT

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the **hospital confinement** as specified in the *Claim Filing Procedure* section of this document.

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered **covered expenses** subject to the following conditions:

1. When the recipient is covered under this **Plan**, the **Plan** will pay the recipient's **covered expenses** related to the transplant.
2. When the donor is covered under this **Plan**, the **Plan** will pay the donor's **covered expenses** related to the transplant.
3. Expenses **incurred** by the donor who is not ordinarily covered under this **Plan** according to eligibility requirements will be **covered expenses** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this **Plan**. The donor's expense shall be applied to the recipient's **maximum benefit**. In no event will benefits be payable in excess of the **maximum benefit** still available to the recipient.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a **covered expense** under this **Plan**.

If a **covered person's** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Centers of Excellence Program

In addition to the above transplant benefits, the **covered person** may be eligible to participate in a Centers of Excellence Program. **Covered persons** should contact the **Health Care Management Organization** to discuss this benefit by calling:

1-800-480-6658

A Center of Excellence is a **facility** within a Centers of Excellence Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Centers of Excellence **facilities** have greater transplant volumes and surgical team experience than other similar **facilities**.

For transplant procedures performed in a Centers of Excellence **facility**, **covered expenses** include charges for transportation, lodging and meals for the covered recipient and one (1) other person (two (2) other persons if the recipient is an eligible **dependent** child) to accompany the recipient to and from a **facility** and for lodging and meals at or near the **facility** where the recipient is confined, subject to the **maximum benefit** as shown on the *Schedule of Benefits*.

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the **hospital confinement** as specified in the *Claim Filing Procedure* section of this document.

PREGNANCY

Covered expenses shall include services, supplies and treatment related to **pregnancy** or **complications of pregnancy** for a covered female **employee**, a covered female spouse/domestic partner of a covered **employee**, and **dependent** female children.

The **Plan** shall cover services, supplies and treatments for abortions or complications from an abortion.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a **birthing center** provided the **physician** in charge is acting within the scope of his license and the **birthing center** meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a **covered expense** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective surgical sterilization procedures for the covered **employee** or covered spouse/domestic partner. Reversal of surgical sterilization is not a **covered expense**. **Covered expenses** for elective surgical sterilization procedures for women shall be considered under the subsection, *Women's Preventive Services*.

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing and infertility treatment for **employees** and their covered spouse.

Charges for diagnostic services and treatment of infertility shall be subject to the **maximum benefit** as shown on the *Schedule of Benefits*.

CONTRACEPTIVES

Covered expenses shall include charges for medical procedures or supplies related to the use of contraceptives, including contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices. FDA approved contraceptive methods shall be considered under the subsection, *Women's Preventive Services*.

Charges for other contraceptives, including oral contraceptives (birth control pills) and contraceptive devices obtainable by prescription (IUD, diaphragm) shall be covered under the *Prescription Drug Program* only.

WELL NEWBORN CARE

The **Plan** shall cover well newborn care as part of the mother's claim.

Such care shall include, but is not limited to:

1. **Physician** services.
2. **Hospital** services.
3. Circumcision.

WELL CHILD CARE

Covered expenses for ***well child care*** shall include charges for the following services provided to covered ***dependent*** children, through eighteen (18) years of age: routine pediatric examinations for a reason other than to diagnose an ***injury*** or ***illness***; immunizations; laboratory and other tests given in connection with pediatric examinations.

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Covered expenses for ***covered person's*** age nineteen (19) and over shall include the following routine preventive care/wellness services and supplies that are not required due to ***illness*** or ***injury***:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Annual routine mammograms for women age thirty-five (35) and over.
3. Colonoscopies for adults.
4. Annual routine prostate specific antigen (PSA) tests for men age forty (40) and over.
5. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents aged seven (7) through eighteen (18) years and adults aged nineteen (19) years and older.
6. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.
7. Physical examination and health history;
8. Computerized health inventory assessment;
9. Blood pressure check;
10. Non-fasting finger stick cholesterol check;
11. Tetanus immunizations for ***covered persons*** if not received in previous ten (10) years; and influenza vaccine when medically appropriate;
12. Hearing exams;
13. Other medically appropriate diagnostic tests and procedures; and
14. Health promotion and health education counseling, videos and brochures.

The ***Plan*** will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

The ***Plan*** will not provide coverage for the above referenced routine preventive care services, immunizations, screenings or supplies until the ***Plan*** year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

Routine preventive care/wellness benefits are subject to the ***maximum benefit*** as specified on the ***Schedule of Benefits***.

WOMEN'S PREVENTIVE SERVICES

Covered expenses shall include the following preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration:

1. Annual well-woman office visits to obtain preventive care;
2. Screening for gestational diabetes in a pregnant woman:
 - a. Between twenty-four (24) and twenty-eight (28) weeks of gestation; and
 - b. At the first prenatal visit for a pregnant woman identified to be at high risk for diabetes.
3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;

4. Annual counseling for sexually transmitted infections for a sexually active woman;
5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;
6. FDA approved contraceptive methods, sterilization procedures and patient education and counseling for a woman with reproductive capacity;
7. Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less costly, of breastfeeding equipment; and
8. Annual screening and counseling for interpersonal and domestic violence.

The **Plan** will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

The **Plan** will not provide coverage for the above referenced women's preventive services until the **Plan** year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

THERAPY SERVICES

Therapy services must be ordered by a **physician** to aid restoration of normal function lost due to **illness** or **injury**, or for prevention of continued deterioration of function.

Covered expenses shall include:

1. Services of a **professional provider** for physical therapy, occupational therapy, speech therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a **covered expense** provided the **covered person** is under a **physician's** continuous care and the **physician** certifies that the **covered person** must have twenty-four (24) hours-per-day nursing care.

If the **covered person** is discharged from the **extended care facility** and again becomes an **inpatient** in such **facility** within fourteen (14) days of the original discharge, it is considered one (1) period of **confinement**.

Covered expenses shall include:

1. **Room and board** (including regular daily services, supplies and treatments furnished by the **extended care facility**) limited to the **facility's** average **semiprivate** room rate; and
2. Other services, supplies and treatment ordered by a **physician** and furnished by the **extended care facility** for **inpatient** medical care.

Extended care facility benefits are subject to the **maximum benefit** specified on the *Schedule of Benefits*.

HOME HEALTH CARE

Home health care enables the **covered person** to receive treatment in his home for an **illness** or **injury** instead of being confined in a **hospital** or **extended care facility**. **Covered expenses** shall include the following services and supplies provided by a **home health care agency**:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse, or a Licensed Vocational Nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent **home health aide services** for a **covered person** who is receiving covered nursing or therapy services;
4. Infusion therapy.
5. Medical social service consultations;
6. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be **medically necessary**.

Covered expenses shall be subject to the **maximum benefit** specified on the *Schedule of Benefits*. A visit by a member of a home health care team and four (4) hours of **home health aide service** will each be considered one (1) home health care visit.

No home health care benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of **durable medical equipment** or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in **outpatient** settings, or in **facility** settings for a **covered person** suffering from a condition that has a terminal prognosis.

Hospice care will be covered only if the **covered person's** attending **physician** certifies that:

1. The **covered person** is terminally ill, and
2. The **covered person** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. **Confinement** in a **hospice** to include ancillary charges and **room and board**.
2. Services, supplies and treatment provided by a **hospice** to a **covered person** in a home setting.
3. **Physician** services and/or nursing care by a Registered Nurse, Licensed Practical Nurse, or a Licensed Vocational Nurse.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be **medically necessary**.
6. Counseling services provided through the **hospice**.
7. Homemaker services.

8. Respite care by an aide who is employed by the *hospice* for up to four (4) hours per day. (Respite care provides care of the *covered person* to allow temporary relief to family members or friends from the duties of caring for the *covered person*).
9. Bereavement counseling as a supportive service to *covered persons* in the terminally ill *covered person's* immediate family. Benefits will be payable provided:
 - a. On the date immediately before death, the terminally ill person was covered under the *Plan* and receiving *hospice* care benefits; and
 - b. Services are *incurred* by the *covered person* within twelve (12) months of the terminally ill person's death.

Charges *incurred* during periods of remission are not eligible under this provision of the *Plan*. Any *covered expense* paid under *hospice* benefits will not be considered a *covered expense* under any other provision of this *Plan*.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly (except as noted below for oxygen concentrators), of *medically necessary durable medical equipment* which is prescribed by a *physician* and required for therapeutic use by the *covered person* shall be a *covered expense*. A charge for the purchase or rental of *durable medical equipment* is considered *incurred* on the date the equipment is received/delivered. *Durable medical equipment* that is received/delivered after the termination date of a covered person's coverage under this Plan is not covered. Repair or replacement of purchased *durable medical equipment* which is *medically necessary* due to normal use or a physiological change in the patient's condition will be considered a *covered expense*.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the *covered person's* condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the *covered person's* medical needs.

Ongoing rental charges for oxygen concentrators shall be a *covered expense*, provided the equipment is determined to be *medically necessary* for the treatment of chronic conditions or upon diagnosis of severe lung disease or other hypoxia related symptoms or findings.

Covered expenses for the rental or purchase, whichever is less costly, of breastfeeding equipment shall be considered under the subsection, *Women's Preventive Services*.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a *covered expense*. A charge for the purchase of a prosthesis is considered *incurred* on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a *covered person's* coverage under this *Plan* is not covered. Repair or replacement of a prosthesis which is *medically necessary* due to normal use or a physiological change in the patient's condition will be considered a *covered expense*.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a *covered expense*. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet

shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement.

Custom cast foot orthotics shall be a *covered expense*, subject to the *maximum benefit* as shown on the *Schedule of Benefits*.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an *injury*. Treatment must begin within six (6) months of the date of such *injury*. Damage to the teeth as a result of chewing or biting shall not be considered an *injury* under this benefit. **Note:** Any group dental plan that the *covered person* may have is considered primary and must be exhausted before benefits will be considered under this *Plan*.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and non-surgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a *covered expense*, but shall not include orthodontia or prosthetic devices prescribed by a *physician* or *dentist*. **Note:** Any group dental plan that the *covered person* may have is considered primary and must be exhausted before benefits will be considered under this *Plan*.

ORTHOGNATHIC DISORDERS

Surgical and non-surgical treatment of orthognathic disorders shall be a *covered expense*, but shall not include orthodontia or prosthetic devices prescribed by a *physician* or *dentist*.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include *medically necessary* special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of *illness* or *injury* of the eye; support stockings, such as Jobst stockings, surgical dressings and other medical supplies ordered by a *professional provider* in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or *reconstructive surgery* shall be a *covered expense* provided:

1. A *covered person* receives an *injury* as a result of an *accident* and as a result requires surgery. *Cosmetic* or *reconstructive surgery* and treatment must be for the purpose of restoring the *covered person* to his normal function immediately prior to the *accident*.
2. It is required to correct a congenital anomaly, for example, a birth defect, for a child until age 25.

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

This *Plan* intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to *medically necessary* mastectomy.

For a **covered person** who elects breast reconstruction in connection with such mastectomy, **covered expenses** will include:

1. Reconstruction of a surgically removed breast; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and **medically necessary** replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered **covered expenses** following all **medically necessary** mastectomies.

MENTAL & NERVOUS DISORDERS AND CHEMICAL DEPENDENCY CARE

Inpatient or Partial Confinement

Subject to the pre-certification provisions of the **Plan**, the **Plan** will pay the applicable **coinsurance**, as shown on the *Schedule of Benefits*, for **confinement** in a **hospital** or **treatment center** for treatment, services and supplies related to the treatment of **mental and nervous disorders** and **chemical dependency**. Two (2) days of **partial confinement** will be considered as one day of **inpatient confinement**.

Covered expenses shall include:

1. ***Inpatient hospital confinement;***
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same **professional provider**.

Outpatient

The **Plan** will pay the applicable **coinsurance**, as shown on the *Schedule of Benefits*, for **outpatient** treatment, services and supplies related to the treatment of **mental and nervous disorders** and **chemical dependency**.

PRESCRIPTION DRUGS

The application of **copays** under the *Prescription Drug Program* shall not be considered a **covered expense** under the *Medical Expense Benefit*.

ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

Covered expenses shall include charges for “routine patient costs” incurred by a “qualified individual” participating in an **approved clinical trial**. “Routine patient costs” do not include:

1. An investigational item, device or service;
2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“Routine patient costs” include all items and services consistent with the coverage provided by the *Plan* that are typically covered for a *covered person* who is not enrolled in a clinical trial.

“Qualified Individual” means a *covered person* who is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or another “life-threatening disease or condition” and either;

1. The referring health care professional has concluded that the *covered person’s* participation in such trial would be appropriate; or,
2. The *covered person* provides medical and scientific information establishing that the *covered person’s* participation in such trial would be appropriate.

“Life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

HEARING BENEFIT

Services of a licensed audiologist to determine and measure hearing loss shall be a *covered expense*. Hearing aids shall be a *covered expense*, subject to the *maximum benefit* as shown on the *Schedule of Benefits*.

PRIVATE DUTY NURSING

Medically necessary services of a private duty *nurse* shall be a *covered expense*.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment.

PATIENT EDUCATION

Covered expenses shall include *medically necessary* patient education programs including, but not limited to diabetic education and ostomy care. *Covered expenses* for patient education for contraception or lactation training shall be considered under the subsection, *Women’s Preventive Services*.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a *professional provider; physician; hospital; facility* or any other health care provider shall be a *covered expense* under the terms of the *Plan*.

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified *medically necessary outpatient* cardiac/pulmonary rehabilitation programs.

SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for surgical treatment of *morbid obesity* for *covered persons* with health problems that are aggravated by or related to the *morbid obesity*, including, but not limited to gastric by-pass, gastric stapling or gastric balloon.

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

ACUPUNCTURE

Acupuncture to induce surgical anesthesia or for therapeutic purposes shall be a *covered expense*.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this *Plan* for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.
2. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery or medical or psychiatric treatment.
3. Charges for treatment or surgery for sexual dysfunction or inadequacies.
4. Charges for *hospital* admission on Friday, Saturday or Sunday unless the admission is an *emergency* situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, *hospital* expenses will be payable commencing on the date of actual surgery.
5. Charges for *inpatient room and board* in connection with a *hospital confinement* primarily for diagnostic tests, unless it is determined by the *Plan* that *inpatient* care is *medically necessary*.
6. Charges for services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, development delay, hyperactivity or learning disorders. However, the initial examination, office visit and diagnostic testing to determine the *illness* shall be a *covered expense*. *Effective December 1, 2014*, services, supplies and treatment for attention deficit disorders will be considered a *covered expense*.
7. Charges for biofeedback therapy.
8. Charges for services, supplies or treatments that are primarily educational in nature, except as specified in *Medical Expense Benefit, Patient Education and Women's Preventive Services*; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
9. Charges for marriage, family, career or legal counseling.
10. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of *injury* or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.
11. Charges for routine vision examinations and eye refractions; vision therapy (orthoptics); eyeglasses or contact lenses, except as specified herein; dispensing optician's services. Refer to the section, *Vision Expense Benefit* for additional information.
12. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.
13. Except as *medically necessary* for the treatment of metabolic or peripheral-vascular *illness*, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.
14. Charges for services, supplies or treatment that constitute personal comfort or beautification items, whether or not recommended by a *physician*, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment, convenience items or modifications to the home.

15. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements, except as provided in *Medical Expense Benefit, Routine Preventive Care/Wellness Benefits* United States Preventive Services Task Force (USPSTF) recommendations.
16. Charges for prescription drugs that are covered under the *Prescription Drug Program* or for the prescription drug *copay* applicable thereto. *Outpatient* prescription drugs are paid under the *Prescription Drug Program* and under no other provision of this *Plan*.
17. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.
18. Expenses for a *cosmetic surgery* or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic/Reconstructive Surgery*.
19. Charges *incurred* as a result of, or in connection with, any procedure or treatment excluded by this *Plan* that has resulted in medical complications.
20. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and *hospital confinements* for weight reduction programs, except as specifically provided herein.
21. Charges for surgical weight reduction procedures and all related charges, unless resulting from *morbid obesity*.
22. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, except as mandated under PPACA.
23. Charges for *custodial care*, domiciliary care or rest cures.
24. Charges for travel or accommodations, whether or not recommended by a *physician*, except as specifically provided herein.
25. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise – under any circumstance.
26. Charges for expenses related to hypnosis.
27. Charges for professional services billed by a *professional provider* who is an employee of a *hospital* or any other *facility* and who is paid by the *hospital* or other *facility* for the service provided.
28. Charges for environmental change including *hospital* or *physician* charges connected with prescribing an environmental change.
29. Charges for *room and board* in a *facility* for days on which the *covered person* is permitted to leave (a weekend pass, for example).
30. Charges for chelation therapy, except as treatment of heavy metal poisoning.
31. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.
32. Charges for procurement and storage of one's own blood, unless *incurred* within three (3) months prior to a scheduled surgery.
33. Charges for holistic medicines or providers of naturopathy.

34. Charges for or related to the following types of treatment:
 - a. primal therapy;
 - b. rolfing;
 - c. psychodrama;
 - d. megavitamin therapy;
 - e. visual perceptual training.
35. Charges for structural changes to a house or vehicle.
36. Charges for exercise programs for treatment of any condition, except as specified herein.
37. Charges for drugs, devices, supplies, treatments, procedures or services that are considered *experimental/investigational* by the *Plan*. The *Plan* will consider a drug, device, supply, treatment, procedure or service to be “*experimental*” or “*investigative*”:
 - a. if, in the case of a drug, device or supply, the drug, device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device or supply is furnished; or
 - b. if the drug, device, supply, treatment, procedure or service, or the patient’s informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating *facility’s* institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
 - c. if the *plan sponsor* (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, *experimental*, study or *investigational* arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy; or
 - d. if the *plan sponsor* (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.
38. Charges for any services, supplies or treatment not specifically provided herein.

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with the *Plan* to charge *covered persons* reduced fees for covered prescription drugs.

PHARMACY OPTION COPAY

The *copay* is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The *copay* amount is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a *nonparticipating pharmacy* or a *participating pharmacy* when the *covered person's* ID card is not used, the *covered person* must pay the entire cost of the prescription, including *copay*, and then submit the receipt to the prescription drug card vendor for reimbursement. If a *nonparticipating pharmacy* is used, the *covered person* will be responsible for the *copay*, plus the difference in cost between the *participating pharmacy* and *nonparticipating pharmacy*.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs that may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY

The *copay* is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. The *copay* is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a *physician* that require a prescription either by federal or state law, except drugs excluded by the *Plan* as specified in the subsection, *Expenses Not Covered*.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Over-the-counter (OTC) diabetic medicines and supplies (except for GlucoWatch products).
4. Contraceptives, regardless of the reason prescribed. **Exception:** Contraceptive implants will not be covered by the *Plan*.
5. ADD and narcolepsy drugs.
6. Anabolic steroids.
7. Anorexients (diet aids).
8. Anti-rejection drugs (immunosuppressants).

9. Anti-smoking aids (requiring a prescription).
10. Acne medicines (Tretinoins, Differin or Tazorac).
11. Fluoride (topical fluoride dental products requiring a prescription).
12. Drugs used in the treatment of erectile dysfunction (limited to age eighteen (18) and older only, eight (8) units per thirty (30) day retail or twenty-four (24) units per ninety (90) day mail order).
13. Migraine medicines (kit, nasal spray, tablet, injectables).
14. Multiple Sclerosis medicines (Betaseron, Avonex, Copaxone, Rebif).
15. Multiple vitamins that require a prescription.
16. Inhaler assisting devices.
17. Hemophilia blood factor products.
18. Gleevac.
19. Iressa.
20. Relenza, limited to twenty (20) units or thirty (30) days, whichever is less per claim, retail only.
21. Tamiflu, limited to ten (10) units or thirty (30) days, whichever is less per claim, retail only.
22. Thalomid, limited to a twenty-eight (28) day supply.
23. Yohimbine.
24. Insulin and patient administered injectables, if ordered through the *Specialty Pharmacy Program*.
25. Needles and syringes.
26. Hematinics.
27. Minerals.
28. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a *qualified prescriber*.

LIMITS TO THIS BENEFIT

This benefit applies only when a *covered person* incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a *physician*.
2. Refills up to one year from the date of order by a *physician*.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. 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.
3. Immunization agents or biological sera, blood or blood plasma except if purchased through the *Specialty Pharmacy Program*.
4. A drug or medicine labeled: “Caution - limited by federal law to *investigational* use.”
5. ***Experimental*** drugs and medicines, even though a charge is made to the ***covered person***.
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital*** confined. This includes being confined in any institution that has a ***facility*** for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for Minoxidil.
11. A charge for Levonorgestrel.
12. A charge for non-legend drugs, other than as specifically listed herein.

Any prescription drug covered under the *Prescription Drug Program* will not be covered under the *Medical Expense Benefit*, except as specified in *Medical Expense Benefit, Prescription Drugs*.

SPECIALTY PHARMACY PROGRAM

Specialty drugs are defined as high-cost prescription drugs that treat complex conditions, require special handling, special administration, and are generally not available at local retail pharmacies. The prescription drug benefit covers select specialty drugs (both injectable and oral medications) through CVS Caremark’s specialty mail order service for the following conditions:

Allergic Asthma

Crohn’s disease

Enzyme replacement for Lysosomal Storage Disorder

Gaucher disease

Growth hormone disorders

Hematopoietics

Hemophilia, Von Willebrand disease and related bleeding disorders

Hepatitis C

Hormonal therapies

Immune deficiencies
Multiple Sclerosis
Oncology
Osteoarthritis
Psoriasis
Pulmonary Arterial Hypertension
Pulmonary disease
Renal disease
Respiratory Syncytial Virus
Rheumatoid Arthritis
Other Disorders

To take advantage of this program, the **covered person** will need to transfer the related prescription to CVS Caremark. To transfer a prescription, call 1-800-237-2767. A representative of CVS Caremark will call the **covered person's physician** to take care of the appropriate paperwork.

The medication will be shipped to a location of the **covered person's** choice (home or **physician's** office) from a CVS Caremark specialty mail order pharmacy. CVS Caremark's clinical staff will follow up with the **covered person** via phone and letters to provide ongoing coaching on complex therapies (injection training if appropriate), potential side effects, staying adherent, and assisting with any therapy related questions.

NOTICE OF AUTHORIZED REPRESENTATIVE

The **covered person** may provide the **plan administrator** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a **covered person** and consent to release of information related to the **covered person** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

APPEALING A DENIED POST- SERVICE PRESCRIPTION DRUG CLAIM

The "named fiduciary" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the **claims processor**.

A **covered person**, or the **covered person's** authorized representative, may request a review of a denied claim by making written request to the **named fiduciary** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the **covered person** feels the claim should not have been denied.

The following describes the review process and rights of the **covered person**:

1. The **covered person** has the right to submit documents, information and comments and to present evidence and testimony.
2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
3. Before a final determination on appeal is rendered, the **covered person** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the **Plan** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the **covered person** a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the **covered person**, even if it was not considered in the initial benefit determination.

5. The review by the **named fiduciary** will not afford deference to the original denial.
6. The **named fiduciary** will not be:
 - a. The individual who originally denied the claim, nor
 - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
 - a. The **named fiduciary** will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment; and
 - b. The **professional provider** utilized by the **named fiduciary** will be neither:
 - i. An individual who was consulted in connection with the original denial of the claim, nor
 - ii. A subordinate of any other **professional provider** who was consulted in connection with the original denial.
8. If requested, the **named fiduciary** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific **Plan** provisions on which the denial is based.
3. A statement that the **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
4. A statement of the **covered person's** right to request an external review and a description of the process for requesting such a review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on **medical necessity, experimental/investigational** treatment or similar exclusion or limit, the **plan administrator** (or its designee) will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the **Plan** to the claimant's medical circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

A **covered person**, or the **covered person's** authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the **named fiduciary** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. **Medical necessity**;
2. Appropriateness;
3. **Experimental** or **investigational** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a **covered expense**.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {*Note:*

If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.} The **Plan** may charge a filing fee to the **covered person** requesting an external review, subject to applicable laws and regulations.

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the **claims processor** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this **Plan**.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the **covered person** to perfect the external review request by the later of the following:
 - a. The four (4) month filing period; or
 - b. Within the forty-eight (48) hour time period following the **covered person's** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the **covered person** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the **plan administrator** (or its designee) and the **covered person** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the **covered person**, the **Plan** and **claims processor**, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) the right to request an expedited external review upon the **covered person's** receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the **covered person** or the **covered person's** ability to regain maximum function and the **covered person** has filed an internal appeal request.

2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the **covered person** or the **covered person's** ability to regain maximum function or if the final denial involves any of the following:
 - a. An admission,
 - b. Availability of care,
 - c. Continued stay, or
 - d. A health care item or service for which the **covered person** received **emergency services**, but has not yet been discharged from a **facility**.

Immediately upon receipt of the request for *Expedited External Review*, the **Plan** will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.
2. Send notice of the **Plan's** decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the **Plan** will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the **covered person's** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the **plan administrator** (or its designee) and the **covered person** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

VISION EXPENSE BENEFIT

The UHC Vision Care Program, not CoreSource, administers vision benefits. The following provisions are provided for informational purposes only.

UHC's Vision Care Program provides affordable, quality vision care, nationwide. Through UHC's provider network, you will receive a comprehensive vision examination, as well as materials (if needed).

Carefully review the summary of your Vision Care Program. Please, don't take chances with your most precious possession – the gift of sight. Take advantage of this very important benefit. If you have questions or concerns about your vision options, please contact UHC's Customer Service Center at:

1-800-638-3120
Monday through Friday 8:30 a.m. to 8:00 p.m. ET
Saturday 9:00 a.m. to 5:00 p.m. ET
www.myuhcvision.com

NETWORK BENEFITS

When using a network provider, enrolled participants and eligible dependents are qualified for the following:

1. **Examination:** After the exam copay of \$10, a comprehensive vision examination is covered-in-full once every 12 months when provided by a network optometrist or ophthalmologist.
2. **Materials:** After the materials copay of \$0, standard lenses are covered once every 12 months and frames from UHC's selection are covered once every 12 months or you may select contact lenses in lieu of lenses and frames once every 12 months.
3. **Pair of Lenses:** If prescribed, a pair of standard single vision or standard multi-focal lenses is covered-in-full.
4. **Lens Options: Standard scratch-resistant coating is covered-in-full.** Should you choose lens options not covered by the program, such as, but not limited to, progressive lenses, polycarbonate lenses, high index, tints, UV, and anti-reflective coating, you may be able to purchase these options at a discount.
5. **Frames:** Your choice from a wide selection of fashionable frames will be covered. If you select a frame outside of UHC's covered-in-full selection, you will receive a \$50 wholesale frame allowance at private practice providers, or a minimum \$120 retail frame allowance at our retail chain providers.
6. **Contact Lenses:** In lieu of lenses and frames, you may select contact lenses. UHC's covered contact lens benefit includes the fitting/evaluation fees, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included if obtained from a network provider. It is important to note that UHC's covered contact lenses may vary by provider. Should you choose contact lenses outside of the covered selection, a \$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses once every 12 months (materials copay does not apply). Toric, gas permeable, and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts covered-in-full after applicable copay.
7. **Refractive Eye Surgery:** UHC participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.myuhcvision.com.

If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth to:

UHC Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Please note: Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement.

UHC will reimburse you according to the schedule shown above.

PROVIDER LOCATOR

With UHC, you are able to choose from network private practice providers and retail chain providers. Prior to enrolling in or using the UHC vision care program, if you would like to identify a network provider, visit UHC's web site - www.myuhcvision.com - and provider locator or call UHC's Provider Locator Service at 1-800-638-3120 and follow the voice prompts:

1. Enter the primary insured's unique identification number.
2. Enter the ZIP code for the area you wish to check.
3. After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect.
4. The system will then identify up to three network providers in the requested ZIP code area.
5. If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2".

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a UHC participant.

IMPORTANT TO REMEMBER

1. Always identify yourself as a UHC participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
2. Your \$150 contact lens allowance is applied to the fitting/evaluation fee and the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$120 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are examples of contacts that are outside of our covered-in-full selection.
3. Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement.
4. Benefits for contact lenses are in lieu of lenses and frames. Your provider will help you determine which contact lenses are covered under your benefit.
5. Benefits available every 12 months, based on last date of service.
6. Lens options such as UV coating, progressive lenses, etc., are not covered-in-full but are provided to UHC members at a savings below usual and customary charges.

The following services and materials are excluded from coverage under the plan:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease that requires the services of a physician.
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or program
6. Services or materials that are not specifically covered by the plan
7. Sunglasses, plain or prescription
8. Replacement or repair of lenses and/or frames that have been lost or broken

Please note: If there are differences in this provision and the Group Policy, the Group Policy is the governing document.

PLAN EXCLUSIONS

The *Plan* will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *physician* or *professional provider*.

1. Charges for services, supplies or treatment from any *hospital* owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an *injury* sustained or *illness* contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, treatment or supplies for treatment of *illness* or *injury* that is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the *covered person* fails to claim rights to such benefits or fails to enroll or purchase such coverage. This does not include a *covered person* that is a sole proprietor, partner or executive officer that is not required by law to have workers' compensation or similar coverage and does not have such coverage.
5. Charges in connection with any *illness* or *injury* arising out of or in the course of any employment intended for wage or profit, including self-employment.
6. Charges made for services, supplies and treatment which are not *medically necessary* for the treatment of *illness* or *injury*, or which are not recommended and approved by the attending *physician*, except as specifically stated herein, or to the extent that the charges exceed *customary and reasonable amount* or exceed the *negotiated rate*, as applicable. **Exception:** chiropractic care and acupuncture expenses are not limited by the *medical necessity* requirement.
7. Charges in connection with any *illness* or *injury* of the *covered person* resulting from or occurring during commission or attempted commission of a criminal battery or felony by the *covered person*. This exclusion will not apply to an *illness* and/or *injury* sustained due to a medical condition (physical or mental) or domestic violence.
8. To the extent that payment under this *Plan* is prohibited by any law of any jurisdiction in which the *covered person* resides at the time the expense is *incurred*.
9. Charges for services rendered and/or supplies received prior to the *effective date* or after the termination date of a person's coverage.
10. Any services, supplies or treatment for which the *covered person* is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
11. Charges for services, supplies or treatment that are considered *experimental/investigational*.

12. Charges **incurred** outside the United States if the **covered person** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.
13. Charges for services, supplies or treatment rendered by any individual who is a **close relative** of the **covered person** or who resides in the same household as the **covered person**.
14. Charges for services, supplies or treatment rendered by **physicians** or **professional providers** beyond the scope of their license; for any treatment, **confinement** or service that is not recommended by or performed by an appropriate **professional provider**.
15. Charges for **illnesses** or **injuries** suffered by a **covered person** due to the action or inaction of any party if the **covered person** fails to provide information as specified in the section, *Subrogation/Reimbursement*.
16. Claims not submitted within the **Plan's** filing limit deadlines as specified in the section *Claim Filing Procedure*.
17. Charges for telephone or e-mail consultations, completion of claim forms, charges associated with missed appointments.
18. If the primary plan provides coverage through the services of an HMO and the **covered person** chooses not to use the HMO, this **Plan** will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO, if shown on the primary carrier's explanation of benefits.
19. This **Plan** will not pay for any charge that has been refused by another plan covering the **covered person** as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the *Plan's* requirements for a person to participate in the *Plan*.

EMPLOYEE ELIGIBILITY

Employees whose employment is governed by a collective bargaining unit have guaranteed access to this *Plan*. Otherwise, *employees* who are considered management or confidential *employees*, working a minimum of twenty (20) hours per week, shall be eligible to enroll for coverage under this *Plan*. This does not include temporary or seasonal *employees*.

The *Plan* is required to inform members of the eligibility requirements.

EMPLOYEE ENROLLMENT

An *employee* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for himself within thirty-one (31) days of becoming eligible for coverage. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

EMPLOYEE(S) EFFECTIVE DATE

Eligible *employees*, as described in *Employee Eligibility*, are covered under the *Plan* on the first day of the month following the date of hire, provided the *employee* has enrolled for coverage as described in *Employee Enrollment*.

DEPENDENT(S) ELIGIBILITY

1. The term "spouse" means the spouse of the *employee* under a legally valid existing marriage, as defined by the state in which the *employee* was legally married, unless court ordered separation exists.

The term "domestic partner" means that the *dependent*:

- a. Is the same or opposite sex as the *employee*;
- b. Is at least eighteen (18) years of age and competent to enter into a contract;
- c. Is not legally married or the domestic partner of another individual;
- d. Is not related to the *employee* by blood closer than which would bar marriage in the State of California;
- e. Has allowed at least six (6) months to pass since the termination of any previous domestic partnership; and
- f. Has lived as a couple with the *employee* in a shared residence for at least six (6) consecutive months.

Or, the requirements for registration of domestic partner status in the State of California are as follows (**registration process will be conducted at the California Secretary of State Office**):

- a. Both persons must have a common residence;
- b. Neither person may be married to someone else or have another domestic partner;
- c. The two individuals may not be related by blood in a way that would prevent them from being married to each other;
- d. Both individuals must be at least eighteen (18) years of age;

- e. Both individuals must be of the same sex, or one individual must be at least age sixty-two (62) and be qualified to receive Social Security retirement benefits or Supplemental Security Income (SSI) benefits. More details on filing can be found at www.ss.ca.gov/dpregistry.
2. The term "child" means the *employee's* or domestic partner's natural child, stepchild, legally adopted child, child *placed for adoption*, and a child for whom the *employee* or covered spouse/domestic partner has been appointed legal guardian, provided the child is less than twenty-six (26) years of age.
3. An eligible child shall also include any other child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*. Such child shall be referred to as an *alternate recipient*. *Alternate recipients* are eligible for coverage regardless of whether the *employee* elects coverage for himself. An application for enrollment must be submitted to the *employer* for coverage under this *Plan*. The *employer/plan administrator* shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the *Plan* pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the *employer/plan administrator* shall determine whether such order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

The *employer/plan administrator* reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. A *dependent* child who was covered under the *Plan* prior to reaching the maximum age limit of twenty-six (26) years and who lives with the *employee*, is unmarried, incapable of self-sustaining employment and dependent upon the *employee* for support due to a mental and/or physical disability, will remain eligible for coverage under this *Plan* beyond the date coverage would otherwise terminate.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the *employer* or *claims processor*, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

- a. Cessation of the mental and/or physical disability;
- b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible *employee* may enroll eligible *dependents*. However, if both the husband and wife are *employees*, they may choose to have one covered as the *employee*, and the spouse/domestic partner covered as the *dependent* of the *employee*, or they may choose to have both covered as *employees*. Eligible *employees* may be enrolled as both an *employee* and as a *dependent*. Eligible children may be enrolled as *dependents* of one spouse/domestic partner, but not both.

DEPENDENT ENROLLMENT

An *employee* must file a written application (or electronic, if applicable) with the *employer* for coverage hereunder for his eligible *dependents* within thirty-one (31) days of becoming eligible for coverage and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The *employee* shall have the responsibility of timely forwarding to the *employer* all applications for enrollment hereunder.

DEPENDENT(S) EFFECTIVE DATE

Eligible *dependent(s)*, as described in *Dependent(s) Eligibility*, will become covered under the *Plan* on the later of the dates listed below, provided the *employee* has enrolled them in the *Plan* within thirty-one (31) days of meeting the *Plan's* eligibility requirements and any required contributions are made.

1. The date the *employee's* coverage becomes effective.
2. The date the *dependent* is acquired, provided the *employee* has applied for *dependent* coverage within thirty-one (31) days of the date acquired.
3. Newborn children shall be covered from birth, provided the *employee* has applied for *dependent* coverage within thirty-one (31) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is *placed for adoption*, provided the *employee* has applied for *dependent* coverage within thirty-one (31) days of the date the child is *placed for adoption*.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An *employee* or *dependent* who did not enroll for coverage under this *Plan* because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this *Plan*, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits).
2. Cessation of employer contributions toward the other coverage.
3. Legal separation, divorce or termination of domestic partnership.
4. Termination of other employment or reduction in number of hours of other employment.
5. Death of *dependent* or spouse/domestic partner.
6. Cessation of other coverage because *employee* or *dependent* no longer resides or works in the service area and no other benefit package is available to the individual.
7. Cessation of *dependent* status under other coverage and *dependent* is otherwise eligible under *employee's Plan*.
8. An incurred claim that would exceed the other coverage's maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.

Notwithstanding any provision of the *Plan* to the contrary, all benefits received by an individual under any benefit option, package or coverage under the *Plan* shall be applied toward any applicable *Essential Health Benefits/non-Essential Health Benefits maximum benefit* paid by the *Plan* for any one *covered person* for such option, package or coverage under the *Plan*, and also toward any applicable *Essential Health Benefits/non-Essential Health Benefits maximum benefit* under any other options, packages or coverages under the *Plan* in which the individual may participate in the future.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The *employee* or *dependent* must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An **employee** who is currently covered or not covered under the **Plan**, but who acquires a new **dependent** may request a special enrollment period for himself, if applicable, his newly acquired **dependent** and his spouse, if not already covered under this **Plan** and otherwise eligible for coverage. For the purposes of this provision, the acquisition of a new **dependent** includes:

1. Marriage or domestic partnership.
2. Birth of a **dependent** child.
3. Adoption or **placement for adoption** of a **dependent** child.

The **employee** must request the special enrollment within thirty-one (31) days of the acquisition of the **dependent**.

The **effective date** of coverage as the result of a special enrollment shall be:

1. In the case of marriage or domestic partnership, the date of the event;
2. In the case of a **dependent's** birth, the date of such birth;
3. In the case of adoption or **placement for adoption**, the date of such adoption or **placement for adoption**.

SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)

This **Plan** intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An **employee** who is currently covered or not covered under the **Plan** may request a special enrollment period for himself, if applicable, and his **dependent**. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,
2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The **employee** or **dependent** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

OPEN ENROLLMENT

Open enrollment is the period designated by the **employer** during which the **employee** may change benefit plans or enroll in the **Plan** if he did not do so when first eligible or does not qualify for a special enrollment period.

For Active and Post-2012 Retirees – An open enrollment will be permitted once in each calendar year during the month of May. The **effective date** of coverage as the result of an open enrollment period will be the following July 1st.

For Spring Part-Time Hourly Faculty – An open enrollment will be permitted once in each calendar year between January 20th and February 20th. The **effective date** of coverage as the result of an open enrollment period will be the following March 1st.

For Fall Part-Time Hourly Faculty – An open enrollment will be permitted once in each calendar year between August 20th and September 20th. The *effective date* of coverage as the result of an open enrollment period will be the following September 1st.

During this open enrollment period, an *employee* and his *dependents* who are covered under this *Plan* or covered under any *employer* sponsored health plan may elect coverage or change coverage under this *Plan* for himself and his eligible *dependents*. An *employee* must make written application (or electronic, if applicable) as provided by the *employer* during the open enrollment period to change benefit plans.

Except for a status change listed below, the open enrollment period is the only time an *employee* may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
 - a. Change in *employee's* legal marital or domestic partner status;
 - b. Change in number of *dependents*;
 - c. Termination or commencement of employment by the *employee*, spouse or *dependent*;
 - d. Change in work schedule;
 - e. *Dependent* satisfies (or ceases to satisfy) *dependent* eligibility requirements;
 - f. Change in residence or worksite of *employee*, spouse or *dependent*.
2. Significant change in the cost of coverage under the *employer's* group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a *leave of absence* under the Family and Medical Leave Act of 1993.
5. Significant change in the health coverage of the *employee* or spouse/domestic partnership attributable to the spouse/domestic partnership's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.
7. A court order, judgment or decree.
8. Entitlement to *Medicare* or Medicaid, or enrollment in a state child health insurance program (CHIP).
9. A COBRA qualifying event.

TERMINATION OF COVERAGE

Except as provided in the *Plan's Continuation of Coverage (COBRA)* or *Extension of Benefits* provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE COVERAGE

1. The date the *employer* terminates the *Plan* and offers no other group health plan.
2. The last day of the month in which the *employee* ceases to meet the eligibility requirements of the *Plan*.
3. The last day of the month in which employment terminates, as defined by the *employer's* personnel policies.
4. The date the *employee* becomes a full-time, active member of the armed forces of any country.
5. The date the *employee* ceases to make any required contributions.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the *employer* terminates the *Plan* and offers no other group health plan.
2. The date the *employee's* coverage terminates. However, if the *employee* remains eligible for the *Plan*, but elects to discontinue coverage, coverage may be extended for *alternate recipients*.
3. The last day of the month during which such person ceases to meet the eligibility requirements of the *Plan*.
4. The date the *employee* ceases to make any required contributions on the *dependent's* behalf.
5. The date the *employee's dependent* spouse becomes a full-time, active member of the armed forces of any country.
6. The date the *Plan* discontinues *dependent* coverage for any and all *dependents*.
7. The date the *employee's dependent* spouse becomes eligible as an *employee*.

SURVIVING SPOUSE COVERAGE

Upon the death of the *employee*, the surviving spouse shall receive paid medical benefits for himself/herself, all *dependent* children and posthumous children until all such children would no longer be eligible to receive paid medical benefits had the *employee* survived. Said spouse shall then have the option of buying into the District medical benefits program by the timely payment of premiums as stipulated by the District.

- a. Only the surviving spouse and *dependent* children (including posthumous children) covered by the *employee's* medical plan at the time of death of the *employee* are eligible for coverage.
- b. In the event of the death of the *employee* and/or his or her spouse, the *dependent* children and posthumous children of the *employee* shall receive paid medical benefits until all such children would no longer be eligible to receive paid medical benefits had the *employee* survived.

- c. If there are no **dependent** children, the surviving spouse shall have the option of buying into the District medical benefits program by the timely payment of premiums as stipulated by the District, for the lifetime of the spouse or until he/she is no longer eligible under the guidelines identified above.
- d. Eligibility for medical benefits will terminate for the surviving spouse and **dependent** children upon the remarriage of the surviving spouse.
- e. Eligibility for medical coverage will apply only if the surviving spouse and **dependent** children have no other group medical coverage or if the surviving spouse must pay for other group health coverage. Annual documentation will be required.
- f. Coverage under the District's medical plan will be secondary to any other medical coverage.
- g. Eligibility for this benefit replaces COBRA. The surviving spouse and **dependent** children will not be eligible for COBRA.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for **employees** and/or **dependents**, when the **employee** is on an authorized **leave of absence** from the **employer**. In no event will coverage continue for more than the greater of twelve (12) weeks or the time frame contained in the bargaining unit's bylaws after the **employee's** active service ends.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An **employee** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993 (FMLA), as amended, has the right to continue coverage under this **Plan** for up to twelve (12) weeks (twenty-six (26) weeks in certain circumstances). **Employees** should contact the **employer** to determine whether they are eligible under FMLA.

Contributions

During this leave, the **employer** will continue to pay the same portion of the **employee's** contribution for the **Plan**. The **employee** shall be responsible to continue payment for eligible **dependent's** coverage and any remaining **employee** contributions. If the covered **employee** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the **Plan** was terminated during an approved FMLA leave, and the **employee** returns to active work immediately upon completion of that leave, **Plan** coverage will be reinstated on the date the **employee** returns to active work as if coverage had not terminated, provided the **employee** makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.

Repayment Requirement

The **employer** may require **employees** who fail to return from a leave under FMLA to repay any contributions paid by the **employer** on the **employee's** behalf during an unpaid leave. This repayment will be required only if the **employee's** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the **employee's** control.

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If on the date coverage terminates an *employee* or *dependent* is *totally disabled*, benefits will be extended only for the condition causing such *total disability* and only during the uninterrupted continuance of that disability. This extended benefit will terminate on the earlier of the following:

1. The date the person is no longer *totally disabled*;
2. The date the person becomes eligible for *Medicare*;
3. Upon eligibility for coverage in any other group health plan that does not limit coverage for the disabling condition;
4. The date the *maximum benefits* under this *Plan* have been paid on the person's behalf;
5. The end of the year following the year in which disability occurred; or
6. The date this *Plan* terminates.

If COBRA continuation coverage is elected by the *covered person*, this provision for coverage shall apply after the COBRA continuation coverage period ends.

CERTIFICATES OF COVERAGE

The *plan administrator* shall provide each terminating *covered person* with a Certificate of Coverage, certifying the period of time the individual was covered under this *Plan*. For *employees* with *dependent* coverage, the certificate provided may include information on all covered *dependents*. This *Plan* intends to, at all times, comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this *Plan* includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage that may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, and vision benefits as provided under the *Plan*.

This *Continuation of Coverage* provision also applies to domestic partners and the domestic partner's children.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a *covered person* to lose coverage under this *Plan* or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the *employee*.
2. The *employee's* termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the *Plan*. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce, legal separation or termination of domestic partnership from the *employee*.
4. The *employee's* entitlement to *Medicare* benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this *Plan*.
5. A *dependent* child no longer meets the eligibility requirements of the *Plan*.
6. A covered *retiree* and their covered *dependents* whose benefits were substantially eliminated within one (1) year of the *employer* filing for Chapter 11 bankruptcy.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse/domestic partner being divorced, legally separated or the termination of a domestic partnership from a covered *employee*, or a child's loss of *dependent* status, the *employee* or *dependent* must submit a completed Qualifying Event Notification form to the *plan administrator* (or its designee) within sixty (60) days of the latest of:
 - a. The date of the event;
 - b. The date on which coverage under this *Plan* is or would be lost as a result of that event; or
 - c. The date on which the *employee* or *dependent* is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Qualifying Event Notification form is available from the *plan administrator* (or its designee). In addition, the *employee* or *dependent* may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice

and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the *plan administrator* (or its designee) will notify the *employee* or *dependent* of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this *Plan* other than the ones described in Paragraph 1 above, the *employer* must notify the *plan administrator* (or its designee) not later than thirty (30) days after the date on which the *employee* or *dependent* loses coverage under the *Plan* due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the *plan administrator* (or its designee) will furnish the Election Notice to the *employee* or *dependent*.
3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the *plan administrator* (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.
4. In the event an Election Notice is furnished, the eligible *employee* or *dependent* has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the *Plan* on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the *employee* or *dependent* chooses to have continuation coverage, he must advise the *plan administrator* (or its designee) of this choice by returning to the *plan administrator* (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the *plan administrator* (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:
 - a. The date coverage under the *Plan* would otherwise end; or
 - b. The date the person receives the Election Notice from the *plan administrator* (or its designee).
5. Within forty-five (45) days after the date the person notifies the *plan administrator* (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The *Plan* requires that *covered persons* pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the *plan administrator* (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.
2. For a person originally covered as an *employee* or as a spouse/domestic partner, the cost of coverage is the amount applicable to an *employee* if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an *employee*.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan***.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse/domestic partner or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:

1. Death of the ***employee***.
2. Divorce, legal separation or termination of domestic partnership from the ***employee***.
3. The child's loss of ***dependent*** status.

Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

1. The date of that event;
2. The date on which coverage under this ***Plan*** would be lost as a result of that event if the first qualifying event had not occurred; or
3. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Additional Extension Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other ***dependent*** acquired during continuation coverage is not eligible to extend continuation coverage as described above.

A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

1. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60th) day of continuation coverage; and
2. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the *plan administrator* (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

1. The date of the disability determination by the Social Security Administration;
2. The date of the 18-Month Qualifying Event;
3. The date on which the person loses (or would lose) coverage under this *Plan* as a result of the 18-Month Qualifying Event; or
4. The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

Should the disabled person fail to notify the *plan administrator* (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The *Plan* may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

1. The date of the final determination by the Social Security Administration; or
2. The date on which the individual is furnished with a copy of this Plan Document and Summary Plan Description.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.
2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.
3. Thirty-six (36) months from the date continuation began for *dependents* whose coverage ended because of the death of the *employee*, divorce, legal separation or termination of domestic partnership from the *employee*, or the child's loss of *dependent* status.
4. The end of the period for which contributions are paid if the *covered person* fails to make a payment by the date specified by the *plan administrator* (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this *Plan* or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

5. The date coverage under this **Plan** ends and the **employer** offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
6. The date the **covered person** first becomes entitled, after the date of the **covered person's** original election of continuation coverage, to **Medicare** benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
7. The date the **covered person** first becomes covered under any other employer's group health plan after the original date of the **covered person's** election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the **covered person's** pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.
8. For the spouse/domestic partner or **dependent** child of a covered **employee** who becomes entitled to **Medicare** prior to the spouse/domestic partner's or **dependent's** election for continuation coverage, thirty-six (36) months from the date the covered **employee** becomes entitled to **Medicare**.
9. **Retirees**, and widows or widowers of **retirees** who died before substantial elimination of coverage within one (1) year of the **employer's** bankruptcy, are entitled to lifetime continuation coverage. However, if a **retiree** dies after substantial elimination of coverage within one (1) year of the **employer's** bankruptcy, the surviving spouse/domestic partner and **dependent** children may only elect an additional thirty-six (36) months of continuation coverage after the death.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this **Plan** must, at minimum, contain sufficient information so that the **plan administrator** (or its designee) is able to determine from such notice the **employee** and **dependent(s)** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
2. In connection with continuation coverage under this **Plan**, any notice required to be provided by any individual who is either the **employee** or a **dependent** with respect to the qualifying event may be provided by a representative acting on behalf of the **employee** or the **dependent**, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.
3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
 - a. A single notice addressed to both the **employee** and the spouse/domestic partner will be sufficient as to both individuals if, on the basis of the most recent information available to the **Plan**, the spouse/domestic partner resides at the same location as the **employee**; and
 - b. A single notice addressed to the **employee** or the spouse/domestic partner will be sufficient as to each **dependent** child of the **employee** if, on the basis of the most recent information available to the **Plan**, the **dependent** child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

In the event that a **covered person** becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the **covered person's** pre-existing condition, the **covered person's** continuation coverage under the **Plan** will not be affected by enrollment under that other group health plan. This **Plan** shall be primary payer for the **covered expenses** that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** and the ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** and the ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the ***plan administrator*** (or its designee) may require the ***employee*** and the ***employee's dependent*** to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the ***employee*** and the ***employee's dependent*** will be reinstated without a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning this ***Plan***, including any available continuation coverage, can be directed to the ***plan administrator*** (or its designee).

ADDRESS CHANGES

In order to help ensure the appropriate protection of rights and benefits under this ***Plan***, ***covered persons*** should keep the ***plan administrator*** (or its designee) informed of any changes to their current addresses.

CLAIM FILING PROCEDURE

A “pre-service claim” is a claim for a **Plan** benefit that is subject to the prior certification rules, as described in the section, *Pre-Service Claim Procedure*. All other claims for **Plan** benefits are “post-service claims” and are subject to the rules described in the section, *Post-Service Claim Procedure*.

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. California providers medical claims should be submitted to the address noted below:

Anthem BC Prudent Buyer Plan
P.O. Box 60007
Los Angeles, CA 90060-0007

All other providers’ medical claims should be submitted to the local Blue Cross/Blue Shield Plan. Include the 3 digit alpha prefix before the **covered person’s** identification number.

For claims not submitted by a provider:

CoreSource, Inc.
PO Box 2920
Clinton, IA 52733-2920

The date of receipt will be the date the claim is received by the **claims processor**.

2. All claims submitted for benefits must contain all of the following:
 - a. Name of patient.
 - b. Patient’s date of birth.
 - c. Name of **employee**.
 - d. Address of **employee**.
 - e. Name of **employer** and group number.
 - f. Name, address and tax identification number of provider.
 - g. **Employee** Social Security Number.
 - h. Date of service.
 - i. Diagnosis.
 - j. Description of service and procedure number.
 - k. Charge for service.
 - l. The nature of the **accident, injury** or **illness** being treated.

Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

3. All claims not submitted within twelve (12) months from the date the services were rendered will not be a **covered expense** and will be denied.

The **covered person** may ask the health care provider to submit the claim directly to the **claims processor** or to the **Anthem BC Prudent Buyer Plan Organization** as outlined above, or the **covered person** may submit the bill with a claim form. However, it is ultimately the **covered person’s** responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) calendar days after the occurrence or commencement of any services by the ***Plan***, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***plan administrator*** or to any authorized agent of the ***Plan***, with information sufficient to identify the ***covered person***, shall be deemed notice of claim.

TIME FRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the ***claims processor***, and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the ***Plan's*** control.

After a completed claim has been submitted to the ***claims processor***, and if additional information is needed for determination of the claim, the ***claims processor*** will provide the ***covered person*** (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the ***Plan*** expects to make a decision. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim within fifteen (15) calendar days of receipt by the ***claims processor*** of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

If the claim for benefits is denied, the ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
 - a. The denial code and its specific meaning, and
 - b. A description of the ***Plan's*** standards, if any, used when denying the claim.
3. Reference to the ***Plan*** provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the *covered person's* medical circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED POST-SERVICE CLAIM

The “*named fiduciary*” for purposes of an appeal of a denied Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the *claims processor*.

A *covered person*, or the *covered person's* authorized representative, may request a review of a denied claim by making written request to the *named fiduciary* within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the *covered person* feels the claim should not have been denied.

The following describes the review process and rights of the *covered person*:

1. The *covered person* has the right to submit documents, information and comments and to present evidence and testimony.
2. The *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
3. Before a final determination on appeal is rendered, the *covered person* will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the *Plan* in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the *covered person* a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
5. The review by the *named fiduciary* will not afford deference to the original denial.
6. The *named fiduciary* will not be:
 - a. The individual who originally denied the claim, nor
 - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
 - a. The *named fiduciary* will consult with a *professional provider* who has appropriate training and experience in the field involving the medical judgment; and
 - b. The *professional provider* utilized by the *named fiduciary* will be neither:
 - i. An individual who was consulted in connection with the original denial of the claim, nor
 - ii. A subordinate of any other *professional provider* who was consulted in connection with the original denial.
8. If requested, the *named fiduciary* will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person's* right to request an external review and a description of the process for requesting such a review.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on **medical necessity**, **experimental/investigational** treatment or similar exclusion or limit, the **plan administrator** (or its designee) will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the **Plan** to the claimant's medical circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a **covered person** incurs a **covered expense** in a foreign country, the **covered person** shall be responsible for providing the following information to the **claims processor** before payment of any benefits due are payable:

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

PRE-SERVICE CLAIM PROCEDURE

HEALTH CARE MANAGEMENT

Health care management is the process of evaluating whether proposed services, supplies or treatments are **medically necessary** and appropriate to help ensure quality, cost-effective care.

Certification of **medical necessity** and appropriateness by the **Health Care Management Organization** does not establish eligibility under the **Plan** nor guarantee benefits.

FILING A PRE-CERTIFICATION CLAIM

This pre-certification provision will be waived by the **Health Care Management Organization** if the **covered expense** is rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession (**medically necessary** services only).

All **inpatient** admissions, partial hospitalizations, and potentially cosmetic/**investigational** procedures are to be certified by the **Health Care Management Organization**. For non-urgent care, the **covered person** (or their authorized representative) must call the **Health Care Management Organization** at least fifteen (15) calendar days prior to initiation of services. If the **Health Care Management Organization** is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For **urgent care**, the **covered person** (or their authorized representative) must call the **Health Care Management Organization** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the **covered person** needs medical care that would be considered as **urgent care**, then there is no requirement that the **Plan** be contacted for prior approval.

Covered persons shall use the number shown on their I.D. card to contact the **Health Care Management Organization**.

When a **covered person** (or authorized representative) or provider calls the **Health Care Management Organization**, he or she should be prepared to provide all of the following information:

1. **Employee's** name, address, phone number and Social Security Number.
2. **Employer's** name.
3. If not the **employee**, the patient's name, address, phone number.
4. Admitting **physician's** name and phone number.
5. Name of **facility, home health care agency, extended care facility or hospice**.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

*Group health plans 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.*

However, **hospital** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If the **covered person** (or authorized representative) fails to contact the **Health Care Management Organization** prior to the hospitalization and within the timelines detailed above, the amount of benefits payable for **covered expenses incurred** shall be reduced by twenty-five percent (25%) for the purpose of determining benefits payable. If the **Health Care Management Organization** declines to grant the full pre-certification requested, benefits for days not certified as **medically necessary** by the **Health Care Management Organization** shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

*Effective January 1, 2015, if an Anthem **preferred provider** fails to contact the **Health Care Management Organization** prior to the hospitalization, the Anthem **preferred provider** shall not bill the **covered person** for the reduction in the amount of benefits payable due to such failure.*

NOTICE OF AUTHORIZED REPRESENTATIVE

The **covered person** may provide the **plan administrator** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a **covered person** and consent to release of information related to the **covered person** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the **covered person** may be processed without a written authorization if the request or claim appears to the **plan administrator** (or its designee) to come from a reasonably appropriate and reliable source (*e.g., physician's office, individuals identifying themselves as immediate relatives, etc.*).

If the **covered person** has made the choice to use the services offered through an **Anthem BC Prudent Buyer Plan Preferred Provider**, the **covered person** is deemed to have authorized the **Anthem BC Prudent Buyer Plan Preferred Provider** (or its designee) to represent and act on behalf of a **covered person** in submitting a claim for benefits or an appeal and related communications.

TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the **Plan** receives from the **covered person** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the **covered person**, a specific medical condition or symptom, and a specific treatment, service or product for

which prior approval is requested, the **covered person** (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the **Plan**, and if no additional information is required, the **Plan** will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.
3. After a pre-certification request for non-urgent care has been submitted to the **Plan**, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the **Plan**, the **Plan** will, within fifteen (15) calendar days from receipt of the request, provide the **covered person** (or authorized representative) with a notice detailing the circumstances and the date by which the **Plan** expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The **covered person** will have forty-five (45) calendar days to provide the information requested, and the **Plan** will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the **Plan** of the requested information. Failure to respond in a timely and complete manner will result in a denial.

CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required, the **covered person** (or authorized representative) shall call the **Health Care Management Organization** for continuation of certification.

If a **covered person** (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

1. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
2. The **inpatient** admission or ongoing course of treatment involves **urgent care**, and
 - a. The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the **covered person** (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or
 - b. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the **covered person** (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or
 - c. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the **covered person** (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The **covered person** (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the **covered person** (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

If the **Health Care Management Organization** determines that the **hospital** stay or course of treatment should be decreased or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the **Health Care Management Organization** shall:

1. Notify the **covered person** of the proposed change, and

2. Allow the **covered person** to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the **Health Care Management Organization** determines that continued **confinement** is no longer **medically necessary**, additional days will not be certified. (Refer to *Appealing a Denied Pre-Service Claim* discussion below.)

NOTICE OF PRE-SERVICE CLAIM DENIAL

If a pre-certification request is denied in whole or in part, the **plan administrator** (or its designee) shall provide the **covered person** (or authorized representative) with a written Notice of Pre-Service Claim Denial within the time frames above.

The Notice of Pre-Service Claim Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
 - a. The denial code and its specific meaning, and
 - b. A description of the **Plan's** standards, if any, used when denying the claim.
3. Reference to the **Plan** provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the **Plan's** claim appeal procedure and applicable time limits.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If denial was based on **medical necessity**, **experimental/investigational** treatment or similar exclusion or limit, the **plan administrator** (or its designee) will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the **Plan** to the **covered person's** medical circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

The "**named fiduciary**" for purposes of an appeal of a denied Pre-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the **Health Care Management Organization** (refer to the section *Preferred Provider or Nonpreferred Provider, Anthem BC Prudent Buyer Plans*).

A **covered person** (or authorized representative) may request a review of a denied Pre-Service claim by making a verbal or written request to the **named fiduciary** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the **covered person** feels the claim should not have been denied. If the **covered person** (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the **covered person**:

1. The **covered person** has the right to submit documents, information and comments and to present testimony.
2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
3. Before a final determination on appeal is rendered, the **covered person** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the **Plan** in connection with the claim. Such information will be provided as soon as possible and sufficiently in

- advance of the notice of final internal determination to give the *covered person* a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
 5. The review by the *named fiduciary* will not afford deference to the original denial.
 6. The *named fiduciary* will not be:
 - a. The individual who originally denied the claim, nor
 - b. Subordinate to the individual who originally denied the claim.
 7. If original denial was, in whole or in part, based on medical judgment:
 - a. The *named fiduciary* will consult with a *professional provider* who has appropriate training and experience in the field involving the medical judgment.
 - b. The *professional provider* utilized by the *named fiduciary* will be neither:
 - i. An individual who was consulted in connection with the original denial of the claim, nor
 - ii. A subordinate of any other *professional provider* who was consulted in connection with the original denial.
 8. If requested, the *named fiduciary* will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to *urgent care* claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific *Plan* provisions on which the denial is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person's* right to request an external review and a description of the process for requesting a review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
 - a. A copy of that criterion, or
 - b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on *medical necessity, experimental/investigational* treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
 - a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant's medical circumstances, or
 - b. A statement that such explanation will be supplied free of charge, upon request.

SECOND LEVEL VOLUNTARY APPEAL

The *Health Care Management Organization*, upon request by the *covered person* (or authorized representative) following a pre-service determination on appeal, will conduct a second level voluntary appeal. This appeal is comprised of a panel of three *professional providers* that were not consulted in connection with the original pre-service denial. The *covered person's* decision as to whether to submit a previously denied appeal to the voluntary appeal process will have no effect on the *covered person's* rights to any other benefits under the *Plan*. There are no fees or costs imposed as a condition to use of the voluntary appeal process.

Upon receipt of the request to conduct a voluntary appeal, a determination will be made within thirty (30) calendar days. Notification of the outcome of the review will be communicated verbally and in writing.

With respect to pre-service claims, the **Plan** agrees not to later assert a defense of failure to exhaust available administrative remedies against a **covered person** who chooses not to make use of the voluntary appeal process. With respect to pre-service claims, the **Plan** agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

Upon written request, more information about the voluntary appeal process is available, free of charge, from the **Health Care Management Organization**.

CASE MANAGEMENT

In cases where the **covered person's** condition is expected to be or is of a serious nature, the **Health Care Management Organization** may arrange for review and/or case management services from a professional qualified to perform such services. The **plan administrator** shall have the right to alter or waive the normal provisions of this **Plan** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the **Health Care Management Organization** may recommend (or change) alternative:

1. methods of medical care or treatment;
2. equipment; or
3. supplies

that differ from the medical care or treatment, equipment or supplies that are considered **covered expenses** under the **Plan**.

The recommended alternatives will be considered as **covered expenses** under the **Plan** provided the expenses can be shown to be viable, **medically necessary**, and are included in a written case management report or treatment plan proposed by the **Health Care Management Organization**.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that **covered person** or any other **covered person**.

POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE

EXTERNAL APPEAL

A **covered person**, or the **covered person's** authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the **named fiduciary** within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. **Medical necessity**;
2. Appropriateness;
3. **Experimental** or **investigational** treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a **covered expense**.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.*} The **Plan** may charge a filing fee to the **covered person** requesting an external review, subject to applicable laws and regulations.

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the ***claims processor*** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this ***Plan***.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:
 - a. The four (4) month filing period; or
 - b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the ***covered person***, the ***Plan*** and ***claims processor***, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) the right to request an expedited external review upon the ***covered person's*** receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function and the ***covered person*** has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the final denial involves any of the following:
 - a. An admission,
 - b. Availability of care,

- c. Continued stay, or
- d. A health care item or service for which the *covered person* received *emergency services*, but has not yet been discharged from a *facility*.

Immediately upon receipt of the request for *Expedited External Review*, the *Plan* will do all of the following:

- 1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.
- 2. Send notice of the *Plan's* decision, as described in the subsection, *Notice of Right to External Appeal*.

Upon determination that a request is eligible for external review, the *Plan* will do all of the following:

- 1. Assign an IRO as described in the subsection, *Independent Review Organization*.
- 2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the *covered person's* medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the *plan administrator* (or its designee) and the *covered person* (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the **covered person** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this **Plan** will be charged against the **maximum benefit**.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses **incurred** while covered under this **Plan**, part or all of which would be covered under this **Plan**. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this **Plan**.

When this **Plan** is secondary, "Allowable Expense" will include any deductible or **coinsurance** amounts not paid by the Other Plan(s).

This **Plan** is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this **Plan** shall be secondary only.

When this **Plan** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the **covered person** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" also does not include Tricare, **Medicare**, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for **covered persons** in a group, whether on an insured or uninsured basis, including, but not limited to, **hospital** indemnity benefits and **hospital** reimbursement-type plans;
2. **Hospital** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

"This **Plan**" shall mean that portion of the **employer's Plan** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the **covered person** for whom a claim is made has been covered under this **Plan**.

EFFECT ON BENEFITS

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 paid or provided will be recorded as a benefit reserve for the **covered person** and will be used by this **Plan** to pay any Allowable Expenses, not otherwise paid, that are **incurred** by the **covered person**. As each claim is submitted, its plan must do all of the following:

1. Determine its obligation, pursuant to its contract.
2. Determine whether a benefit reserve has been recorded for the **covered person**.
3. Determine whether there are any unpaid Allowable Expenses. This **Plan** will use the **covered person's** recorded benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses **incurred**.

If there is a benefit reserve, the secondary plan will use the **covered person's** benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses incurred during the calendar year. At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve will be created for each new calendar year.

ORDER OF BENEFIT DETERMINATION

Except as provided below in *Coordination with Medicare*, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. No Coordination of Benefits Provision
If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).
2. Member/Dependent
The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.
3. Dependent Children of Parents not Separated or Divorced
The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.
4. Dependent Children of Separated or Divorced Parents
When parents are separated or divorced, the birthday rule does not apply, instead:
 - a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.

- b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.
5. Active/Inactive
The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.
6. Limited Continuation of Coverage
If a person is covered under another group health plan, but is also covered under this **Plan** for continuation of coverage due to the Other Plan's limitation for pre-existing conditions or exclusions, the Other Plan shall be primary.
7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals may be eligible for **Medicare** Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in **Medicare** Parts B and D are available to all individuals who make application and pay the full cost of the coverage.

1. When an **employee** becomes entitled to **Medicare** coverage (due to age or disability) and is still actively at work, the **employee** may continue health coverage under this **Plan** at the same level of benefits and contribution rate that applied before reaching **Medicare** entitlement.
2. When a **dependent** becomes entitled to **Medicare** coverage (due to age or disability) and the **employee** is still actively at work, the **dependent** may continue health coverage under this **Plan** at the same level of benefits and contribution rate that applied before reaching **Medicare** entitlement.
3. If the **employee** and/or **dependent** is also enrolled in **Medicare** (due to age or disability), this **Plan** shall pay as the primary plan. If, however, the **Medicare** enrollment is due to end stage renal disease, the **Plan**'s primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in **Medicare** law and regulations.
4. Notwithstanding Paragraphs 1 to 3 above, if the **employer** (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) **employees**, when a covered **dependent** becomes entitled to **Medicare** coverage due to **total disability**, as determined by the Social Security Administration, and the **employee** is actively-at-work, **Medicare** will pay as the primary payer for claims of the **dependent** and this **Plan** will pay secondary.
5. If the **employee** and/or **dependent** elect to discontinue health coverage under this **Plan** and enroll under the **Medicare** program, no benefits will be paid under this **Plan**. **Medicare** will be the only payor.
6. For a **retiree** eligible for **Medicare** due to age, **Medicare** shall be the primary payor and this **Plan** shall be secondary. If the **retiree** does not elect **Medicare**, but is otherwise eligible due to age, benefits will be denied.

This section is subject to the terms of the **Medicare** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

AUTOMOBILE ACCIDENT BENEFITS

The ***Plan's*** liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the ***covered person's*** state of residence. No benefit reserve will be recorded for savings due to this coordination of benefits. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws.
2. Financial responsibility laws.
3. Other automobile liability insurance laws.

No Fault Automobile Insurance Laws. In no event will the ***Plan*** pay any claim presented by or on behalf of a ***covered person*** for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a ***covered expense***, medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event a ***covered person*** incurs medical expenses as a result of ***injuries*** sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the ***Plan*** up to the amount equal to that deductible.
2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."
 - a. An owner or principal named insured individual under such policy.
 - b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
 - c. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The **Plan** will be secondary to any potentially applicable automobile insurance even if the state’s “financial responsibility law” does not allow the **Plan** to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law nor a “financial responsibility” law, the **Plan** is secondary to automobile insurance coverage or to any other person or entity who caused the **accident** or who may be liable for the **covered person’s** medical expenses pursuant to the general rule for *Subrogation/Reimbursement*.

SUBROGATION/REIMBURSEMENT

The **Plan** is designed to only pay **covered expenses** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a **covered person** in a time of need, however, the **Plan** may pay **covered expenses** that may be or become the responsibility of another person, provided that the **Plan** later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the **Plan**, as well as by applying for payment of **covered expenses**, a **covered person** is subject to, and agrees to, the following terms and conditions with respect to the amount of **covered expenses** paid by the **Plan**:

1. Assignment of Rights (Subrogation). The **covered person** automatically assigns to the **Plan** any rights the **covered person** may have to recover all or part of the same **covered expenses** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the **Plan**. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a **covered person** or paid to another for the benefit of the **covered person**. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the **covered person** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the **Plan** to pursue any claim that the **covered person** may have, whether or not the **covered person** chooses to pursue that claim. By this assignment, the **Plan’s** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
2. Equitable Lien and other Equitable Remedies. The **Plan** shall have an equitable lien against any rights the **covered person** may have to recover the same **covered expenses** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the **Plan**. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the **Plan** has paid **covered expenses** prior to a determination that the **covered expenses** arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the **covered person**, the **covered person’s** attorney, and/or a trust) as a result of an exercise of the **covered person’s** rights of recovery (sometimes referred to as “proceeds”). The **Plan** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **plan administrator**, the **Plan** may reduce any future **covered expenses** otherwise available to the **covered person** under the **Plan** by an amount up to the total amount of Reimbursable Payments made by the **Plan** that is subject to the equitable lien.

This and any other provisions of the **Plan** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court’s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the **Plan** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.

3. Assisting in **Plan’s** Reimbursement Activities. The **covered person** has an obligation to assist the **Plan** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the **covered person**, and to provide the **Plan** with any information concerning the **covered person’s** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit

of the *covered person*. The *covered person* is required to (a) cooperate fully in the *Plan's* (or any *Plan* fiduciary's) enforcement of the terms of the *Plan*, including the exercise of the *Plan's* right to subrogation and reimbursement, whether against the *covered person* or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the *Plan* as a co-payee for the amount of the Reimbursable Payments and notifying the *Plan*), (c) sign any document deemed by the *plan administrator* to be relevant to protecting the *Plan's* subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the *plan administrator* or *claims processor* to enforce the *Plan's* rights.

The *plan administrator* has delegated to the *claims processor* for medical claims the right to perform ministerial functions required to assert the *Plan's* rights with regard to such claims and benefits; however, the *plan administrator* shall retain discretionary authority with regard to asserting the *Plan's* recovery rights.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer***. The ***employer*** is the ***plan administrator***. The ***plan administrator*** shall have full charge of the operation and management of the ***Plan***. The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. Except as otherwise specifically provided in this document, the ***claims processor*** is the ***named fiduciary*** of the ***Plan*** for post-service claim appeals. As the ***named fiduciary*** for appeals, the ***claims processor*** maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***employer*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original *effective date* of this *Plan* was September 1, 2004. Except as otherwise specifically stated, the *effective date* of the modifications contained herein is July 1, 2014.

FRAUD OR INTENTIONAL MISREPRESENTATION

If the *covered person* or anyone acting on behalf of a *covered person* makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the *Plan*, or otherwise misleads the *Plan*, the *Plan* shall be entitled to recover its damages, including legal fees, from the *covered person*, or from any other person responsible for misleading the *Plan*, and from the person for whom the benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of the *covered person* or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under the *Plan* null and void.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this *Plan* shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a *hospital* or to make a free choice of the attending *physician* or *professional provider*. However, benefits will be paid in accordance with the provisions of this *Plan*, and the *covered person* will have higher out-of-pocket expenses if the *covered person* uses the services of a *nonpreferred provider*.

INCAPACITY

If, in the opinion of the *employer*, a *covered person* for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the *Plan* of the qualification of a guardian or personal representative for his estate, the *employer* may on behalf of the *Plan*, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the *Plan's* obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the *employer* or by the *employee* covered under this *Plan* shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this *Plan* or be used in defense to a claim unless they are contained in writing and signed by the *employer* or by the *covered person*, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the *Plan* prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the *Plan*. No such action shall be brought after the expiration of two (2) years from the date the expense was *incurred*, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the **employer** shall not be liable for any obligation of the **covered person incurred** in excess thereof. The **employer** shall not be liable for the negligence, wrongful act, or omission of any **physician, professional provider, hospital**, or other institution, or their employees, or any other person. The liability of the **Plan** shall be limited to the reasonable cost of **covered expenses** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the **plan administrator** is unable to locate the **covered person** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the **covered person** for the forfeited benefits within the time prescribed in the applicable Claim Filing Procedure section of this document.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The **Plan** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a **covered person** or in determining or making any payment of benefits to that individual. The **Plan** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this **Plan** has a legal liability to make payments for the same services, supplies or treatment, payment under the **Plan** will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the **Plan**.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The **Plan**, at its own expense, shall have the right to require an examination of a person covered under this **Plan** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The **Plan** shall not be deemed to constitute a contract between the **employer** and any **employee** or to be a consideration for, or an inducement or condition of, the employment of any **employee**. Nothing in the **Plan** shall be deemed to give any **employee** the right to be retained in the service of the **employer** or to interfere with the right of the **employer** to terminate the employment of any **employee** at any time.

PLAN MODIFICATION AND AMENDMENT

The **employer** may modify or amend the **Plan** PURSUANT TO PREVAILING COLLECTIVE BARGAINING AGREEMENT OR BOARD POLICY, and such amendments or modifications which affect **covered persons** will be communicated to the **covered persons**. Any such amendments shall be in writing, setting forth the modified provisions of the **Plan**, the **effective date** of the modifications, and shall be signed by the **employer's** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the **Plan** on file with the **employer**, or a written copy thereof shall be deposited with such master copy of the **Plan**. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to **covered persons** shall be timely made by the **employer**.

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons***.

Upon termination of this ***Plan***, all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan***, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the ***Plan*** makes any payment that, according to the terms of the ***Plan***, should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the ***Plan's*** or the ***Plan*** designee's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (*i.e.*, ***dependent*** to ***employee***, COBRA to active) and no interruption in coverage has occurred, the ***Plan*** will provide continuous coverage with respect to any deductible(s), ***coinsurance*** and ***maximum benefit***.

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:01 a.m. as may be legally in effect at the address of the ***plan administrator***.

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

HIPAA PRIVACY

The following provisions are intended to comply with applicable *Plan* amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The *Plan* may take the following actions only upon receipt of a *Plan* amendment certification:

1. Disclose protected health information to the *plan sponsor*.
2. Provide for or permit the disclosure of protected health information to the *plan sponsor* by a health insurance issuer or HMO with respect to the *Plan*.

USE AND DISCLOSURE BY PLAN SPONSOR

The *plan sponsor* may use or disclose protected health information received from the *Plan* to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the *privacy rule*.

OBLIGATIONS OF PLAN SPONSOR

The *plan sponsor* shall have the following obligations:

1. Ensure that:
 - a. Any agents (including a subcontractor) to whom it provides protected health information received from the *Plan* agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to such information; and
 - b. Adequate separation between the *Plan* and the *plan sponsor* is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).
2. Not use or further disclose protected health information received from the *Plan*, other than as permitted or required by the *Plan* documents or as *required by law*.
3. Not use or disclose protected health information received from the *Plan*:
 - a. For employment-related actions and decisions; or
 - b. In connection with any other benefit or employee benefit plan of the *plan sponsor*.
4. Report to the *Plan* any use or disclosure of the protected health information received from the *Plan* that is inconsistent with the use or disclosure provided for of which it becomes aware.
5. Make available protected health information received from the *Plan*, as and to the extent required by the *privacy rule*:
 - a. For access to the individual;
 - b. For amendment and incorporate any amendments to protected health information received from the *Plan*; and
 - c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *privacy rule*.

7. Return or destroy all protected health information received from the *Plan* that the *plan sponsor* still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the *Plan* was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
8. Provide protected health information only to those individuals, under the control of the *plan sponsor* who perform administrative functions for the *Plan*; (i.e., eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for *Plan* administrative functions nor to release protected health information to an unauthorized individual.
9. Provide protected health information only to those entities required to receive the information in order to maintain the *Plan* (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the *Plan*).
10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.
11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the *plan sponsor* on behalf of the *Plan*. Specifically, such safeguarding entails an obligation to:
 - a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the *plan sponsor* creates, receives, maintains, or transmits on behalf of the *Plan*;
 - b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
 - c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
 - d. Report to the *Plan* any security incident of which it becomes aware.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA Privacy* section, the *Plan* (or a health insurance issuer or HMO with respect to the *Plan*) may:

1. Disclose summary health information to the *plan sponsor* if the *plan sponsor* requests it for the purpose of:
 - a. Obtaining premium bids from health plans for providing health insurance coverage under the *Plan*; or
 - b. Modifying, amending, or terminating the *Plan*;
2. Disclose to the *plan sponsor* information on whether the individual is participating in the *Plan*, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the *Plan*;
3. Use or disclose protected health information:
 - a. With (and consistent with) a valid authorization obtained in accordance with the *privacy rule*;
 - b. To carry out treatment, payment, or health care operations in accordance with the *privacy rule*; or
 - c. As otherwise permitted or required by the *privacy rule*.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by ***Medicare***; or that has a contract with the ***Preferred Provider Organization*** as a ***preferred provider***. An ***ambulatory surgical facility*** is a ***facility*** that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;
2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;
3. Does not provide ***inpatient*** accommodations; and
4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Anthem BC Prudent Buyer Plan Negotiated Rate

The rate ***Anthem BC Prudent Buyer Plan Preferred Providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Anthem BC Prudent Buyer Plan Organization

An organization who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***.

Anthem BC Prudent Buyer Plan Provider

A ***physician***, ***hospital*** or other health care provider who has an agreement in effect with Anthem BC Prudent Buyer Plan at the time services are rendered. ***Anthem BC Prudent Buyer Plan Preferred Providers*** agree to accept the ***Anthem BC Prudent Buyer Plan negotiated rate*** as payment in full.

Approved Clinical Trial

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other "life-threatening disease or condition" and is further described in accordance with federal law and applicable federal regulations.

Birthing Center

A **facility** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

Refer to the *Summary Plan Description* (SPD) section of this document.

Close Relative

The **employee's** spouse/domestic partner, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the **employee's** spouse.

Coinsurance

The benefit percentage of **covered expenses** payable by the **Plan** for benefits that are provided under the **Plan**. The **coinsurance** is applied to **covered expenses** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from **pregnancy**, but is adversely affected by or caused by **pregnancy**. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic **pregnancy**.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during **pregnancy** even if prescribed by a **physician**; morning sickness; or like conditions that are not medically termed as **complications of pregnancy**.

Concurrent Care

A request by a ***covered person*** (or their authorized representative) to the ***Health Care Management Organization*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***Health Care Management Organization*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility, hospice, or birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***. If the ***covered person*** is discharged from an ***extended care facility*** and again becomes an ***inpatient*** in such ***facility*** within fourteen (14) days of the original discharge, it is considered one (1) period of ***confinement***.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan***, or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan***, and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

Any negotiated fee (where the provider has contracted to accept such fee as payment in full for ***covered expenses*** of the ***Plan***) assessed for services, supplies or treatment by a ***nonpreferred provider***, or a fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical

complications or unusual circumstances which require additional time, skill or experience. Except as to negotiated fees, the **customary and reasonable amount** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this **Plan** is ninety percent (90%) and is applied to CPT and CDT codes or HIAA Code Analysis using Fair Health benchmarking tables.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a **close relative** of the **covered person**, who is practicing within the scope of his license.

Dependent

For further information regarding eligibility for **dependents**, refer to the *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility* section of this document.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an **illness** or **injury**;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered **durable medical equipment**. **Durable medical equipment** includes, but is not limited to: crutches, wheel chairs, **hospital** beds, etc.

Effective Date

The date of this **Plan** or the date on which the **covered person's** coverage commences, whichever occurs later.

Emergency

An accidental **injury**, or the sudden onset of an **illness** where the acute symptoms are of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the **covered person's** life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Emergency Services

With respect to an ***emergency*** medical condition, a medical screening examination that is within the capability of the emergency department of a ***hospital***, including ancillary services routinely available to the emergency department to evaluate such ***emergency*** medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the ***hospital***, as are required to stabilize the patient.

Employee

A member of a bargaining unit in a position that entitles him or her to benefits under applicable collective bargaining agreements or Board of Trustees policy; and a member of management or confidential employees of the District, working a minimum of twenty (20) hours per week shall be eligible to enroll for coverage under this ***Plan***.

Employer

The ***employer*** is Peralta Community College District.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire. For a ***covered person*** who enrolls in the ***Plan*** as the result of a Special Enrollment Period or as the result of late enrollment or open enrollment period, if available, the ***enrollment date*** is first of the month following the date the enrollment form is signed.

Essential Health Benefits

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for ***covered expenses*** incurred for the following services:

1. Ambulatory patient services;
2. Emergency Services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment (***mental and nervous disorder*** and ***chemical dependency***);
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Experimental/Investigational/Investigative

Services, supplies, drugs and treatment that do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** (or its designee) must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** (or its designee) shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims***

processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator (or its designee) will be guided by the following examples of *experimental* services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, *experimental*, study or *investigational* arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an *inpatient* basis, for persons convalescing from *illness* or *injury*, professional nursing services, and physical restoration services to assist *covered persons* to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.
2. Its services are provided for compensation from its *covered persons* and under the full-time supervision of a *physician* or Registered Nurse.
3. It provides twenty-four (24) hour-a-day nursing services.
4. It maintains a complete medical record on each *covered person*.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of *mental and nervous disorders*.
6. It is approved and licensed by *Medicare*.

This term shall also apply to expenses *incurred* in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Full-time

Management and confidential ***employees*** must work a minimum of twenty (20) hours per week. All other employees are governed by their respective bargaining agreements, which specify terms and conditions to enter the self-funded PPO plan.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Health Care Management

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply or treatment is ***medically necessary***. The ***Health Care Management Organization*** is Anthem BC Prudent Buyer Plan.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, that are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.
3. It maintains a complete medical record on each ***covered person***.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a *physician*.
4. It has a Nurse coordinator who is a Registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of *hospice* services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the *covered person*.
9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to *hospitals*.
2. It is engaged primarily in providing medical care and treatment to *ill* and *injured* persons on an *inpatient* basis at the *covered person's* expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *illness* or *injury*; and such treatment is provided by or under the supervision of a *physician* with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a *hospital* and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of *emergency* treatment in a *hospital* outside of the United States.
5. It must be approved by *Medicare*. This condition may be waived in the case of *emergency* treatment in a *hospital* outside of the United States.

Under no circumstances will a *hospital* be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical rehabilitative services where the *covered person* received treatment as a result of an *illness* or *injury*.

The term *hospital*, when used in conjunction with *inpatient confinement* for *mental and nervous disorders* or *chemical dependency*, will be deemed to include an institution which is licensed as a mental *hospital* or *chemical dependency* rehabilitation and/or detoxification *facility* by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or *pregnancy* of a *covered person*.

Incurred or Incurred Date

With respect to a *covered expense*, the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice, or extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;
2. Special lifesaving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to active work.

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan***.
2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:
 - a. The entire time the ***covered person*** is covered under this ***Plan***, or
 - b. A specified period of time, such as a calendar year.
3. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:
 - a. Treatments during a specified period of time, or
 - b. Days of ***confinement***, or
 - c. Visits by a ***home health care agency***.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** (or its designee) to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness or injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and
3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** (or its designee), may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator*** (or its designee) shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Morbid Obesity

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the ***covered person***, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

Named Fiduciary for Post-Service Claim Appeals

CoreSource, Inc.

Named Fiduciary for Pre-Service Claim Appeals

Anthem BC Prudent Buyer Plan or CoreSource, Inc.

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician***, ***hospital***, or other health care provider who does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;
2. A ***physician's*** office, laboratory or x-ray ***facility***; or
3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of ***mental and nervous disorders***.
3. ***Chemical dependency*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted within the ***pharmacy organization***.

Pharmacy Organization

The ***pharmacy organization*** is Caremark, Inc.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a *close relative* of the *covered person* who is practicing within the scope of his license.

Placed For Adoption

The date the *employee* assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"*Plan*" refers to the benefits and provisions for payment of same as described herein. The *Plan* is the Peralta Community College District PPO Traditional and PPO Lite Active and Post July 1, 2012 Retirees Employee Benefit Plan.

Plan Administrator

The *plan administrator* is responsible for the day-to-day functions and management of the *Plan*. The *plan administrator* is the *employer*.

Plan Year End

The *plan year end* is June 30th.

Preferred Provider

A *physician, hospital* or other health care provider who has an agreement in effect with the *Preferred Provider Organization* at the time services are rendered. *Preferred providers* agree to accept the *negotiated rate* as payment in full.

Preferred Provider Organization

The organization, designated by the *plan administrator*, who selects and contracts with certain *hospitals, physicians*, and other health care providers to provide services, supplies and treatment to *covered persons* at a *negotiated rate*. The *Preferred Provider Organization's* name and/or logo is shown on the front of the *covered person's* ID card.

Pregnancy

The physical state which results in childbirth or miscarriage.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license.

Qualified Prescriber

A **physician, dentist** or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with **Plan** documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the **Plan** concerning the denied treatment or benefit for the **covered person's** diagnosis, even if not relied upon.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Retiree

A former **employee** who retired from service of the **employer** and has met the **Plan's** eligibility requirements to continue coverage under the **Plan** as a **retiree**. As used in this document, the term **employee** shall include **retirees** covered under the **Plan**.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. **Room and board** does not include personal items.

Routine Examination

A comprehensive history and physical examination which would include services as defined in **Medical Expense Benefit, Routine Preventive Care/Wellness Benefit**.

Semiprivate

The daily **room and board** charge which a **facility** applies to the greatest number of beds in its **semiprivate** rooms containing two (2) or more beds.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his or her regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
 - a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
 - b. It provides a program of treatment approved by the ***physician***.
 - c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.
 - d. It provides at least the following basic services:
 - i. ***Room and board.***
 - ii. Evaluation and diagnosis.
 - iii. Counseling.
 - iv. Referral and orientation to specialized community resources.

Urgent Care

An ***emergency*** or an onset of severe pain that cannot be managed without immediate treatment.

Urgent Care Facility

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

1. A board-certified ***physician***, a registered nurse (RN) and a registered x-ray technician in attendance at all times;
2. Has x-ray and laboratory equipment and life support systems.

An ***urgent care facility*** may include a clinic located at, operated in conjunction with, or that is part of a regular ***hospital***.

Well Child Care

Preventive care rendered to ***dependent*** children through the age of eighteen (18).