



PRUDENT BUYER AMENDMENT

issued by

BLUE CROSS OF CALIFORNIA

to

SHASTA-TRINITY SCHOOLS INSURANCE GROUP

Blue Cross of California ("Blue Cross") agrees to modify your Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form by this amendment. All other provisions of the Evidence of Coverage Form which are not inconsistent with this amendment remain in effect. Officers of Blue Cross have approved this amendment to become effective July 1, 2004.

The following changes are made to the section entitled **TYPES OF PROVIDERS**:

Under the section entitled **SUMMARY OF BENEFITS - MEDICAL BENEFIT MAXIMUMS**, the following change is made to your *plan*:

The medical benefit maximum, under the **Lifetime Maximum** provision, is increased to **\$5,000,000** during your lifetime.

The section entitled **CALCOBRA CONTINUATION OF COVERAGE** is deleted and replaced by the following:

CALCOBRA CONTINUATION OF COVERAGE

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or
2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. You are not eligible to further continue coverage under CalCOBRA if you (a) are entitled to Medicare; (b) have other coverage or become covered under another group plan, as long as you are not subject to a pre-existing condition limitation under that coverage; or (c) are eligible for or covered under federal COBRA. Coverage under CalCOBRA is available for medical benefits only.

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, we will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify us in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later.

Additional Family Members. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "subscription charge"). This cost will be:

1. 110% of the applicable group rate if your coverage under federal COBRA ended after 18 months; or
2. 150% of the applicable group rate if your coverage under federal COBRA ended after 29 months.

You must make payment to us within the timeframes specified below. We must receive payment of your subscription charge each month to maintain your coverage in force.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first class mail or other reliable means of delivery, in an amount sufficient to pay any required subscription charges and subscription charges due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding subscription charges are due on the first day of each following month.

Grace Period. For every subscription charge due date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any subscription charge due date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the *prior plan*, your coverage may continue under this *plan* for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and subscription charge payment requirements of this *plan* within 30 days of receiving notice that your continuation coverage under the *prior plan* will end.

When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the subscription charge, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For *family members* properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

When the CalCOBRA Continuation Ends. This CalCOBRA continuation will end on the earliest of:

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *agreement* terminates;
3. The end of the period for which subscription charges are last paid;
4. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of our service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the qualifying event under that *prior plan*.

If your CalCOBRA continuation under this *plan* ends in accordance with item 1, you may be eligible for medical conversion coverage. If your CalCOBRA continuation under this *plan* ends in accordance with items 1 or 2, you may be eligible for HIPAA coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

The section entitled **SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS** is deleted and replaced by the following:

SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS

Subject to payment of subscription charges as stated in the *agreement*, coverage under this *plan* may be continued for the *subscriber*, the *subscriber's spouse*, and the *subscriber's former spouse* (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former *spouse*" means: (a) an individual who is divorced from the *subscriber*; or (b) an individual who was married to the *subscriber* at the time of the *subscriber's* death.

Requirements. The *subscriber* and *spouse* may continue coverage under this *plan* if:

1. The *subscriber*, or the *subscriber* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;
2. The *subscriber* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *subscriber* has worked for the employer for at least the prior five years; and
4. The *subscriber* is at least 60 years old on the date employment with the employer ended.

The former *spouse* may continue coverage under this *plan* in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding section.

Notice and Election. The employer will notify the *subscriber* or *spouse* and the former *spouse* of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the *subscriber* and *spouse*, this continuation may be chosen for both, for the *subscriber* only, or for the *spouse* only. The former *spouse* may elect this continuation for himself or herself only.

To elect this continuation, you must notify us in writing within 30 days prior to the date continuation coverage under COBRA or CalCOBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. You must remit the initial subscription charge to us within 45 days after you elect this continuation.

Cost of Coverage. You are required to pay the entire cost of this continuation coverage. You must remit this cost to us each month during the continuation period. We must receive payment of the subscription charge each month in order to continue the coverage in force. The rate for continuation coverage under this section shall be 213% of the applicable *group* rate. For the purpose of determining subscription charges payable, the *spouse* or former spouse continuing coverage alone will be considered to be a *subscriber*.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding subscription charges are due on the first day of each following month (the Subscription Charge Due Date).

Grace Period. For every Subscription Charge Due Date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any Subscription Charge Due Date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying accurate, up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide. We can hold you responsible for any loss or expense we incur because of your failure to do so.

When Continuation Ends. This continuation will end on the earliest of:

1. The end of the period for which subscription charges are last paid;
2. The date the *agreement* terminates;
3. The date, following the election of Senior COBRA, the *subscriber, spouse, or former spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the *subscriber, spouse, or former spouse* first becomes entitled to Medicare;
5. The date the *subscriber, spouse, or former spouse* reaches age 65; or
6. For the *spouse or former spouse*, five years from the date the *spouse's or former spouse's* COBRA or CalCOBRA continuation coverage ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage. If your continuation under this *plan* ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

The section entitled **HIPAA COVERAGE AND CONVERSION** is revised to state that to apply for a conversion plan, you must submit an application to us and make the first subscription charge payment within 63 days of the date your coverage under the *group's plan* ends. This timeframe was formerly 31 days. Also, you are not eligible for a conversion plan if your coverage under this *plan* ends because the *agreement* terminates and is replaced by another group plan within 15 days. This timeframe was formerly 60 days. Please see the evidence of coverage for a complete explanation of the eligibility rules for both HIPAA plans and conversion plans.

The section entitled **GRIEVANCE PROCEDURES** is revised to state that you may submit a grievance to us online or print the Plan Grievance Form through the Blue Cross of California website at **www.bluecrossca.com**. In addition, all grievances must be submitted to us no later than 180 days following the date you receive a denial notice from us or any other action or incident with which you are dissatisfied.

The provision **Review of Denials of Experimental or Investigative Treatment** under the section entitled **GRIEVANCE PROCEDURES** is deleted and replaced by the following:

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. To request an application form, please call us at the telephone number listed on your identification card or write to us at Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
 - ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
 - ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The proposed treatment must be recommended by either (a) a *participating provider* or (b) a board certified or board eligible *physician* qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
- If this review is requested either by you or by a qualified *non-participating provider* (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:
 - a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;

- b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
- c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Information we receive subsequently will be sent to the review panel within three business days. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).