



www.stsigjpa.com

SHASTA-TRINITY SCHOOLS INSURANCE GROUP

PLAN C-2

July 1, 2006

Summary Plan Description

MedCall

Your *plan* includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call MedCall toll free at **800-977-0027**, be prepared to provide your name, the patient's name (if you're not calling for yourself), the *employee's* identification number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs. Based on the information you provide, the advice may be:

- Home self-care. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your *physician*. If you do not have a *physician*, the nurse will help you select one by providing a list of *physicians* who are *participating providers* in your geographical area.
- Call your *physician* for further discussion and assessment.
- To go to an emergency room in a *participating provider hospital*.
- Instructions to immediately call 911.

In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimited access to its Audio Health Library featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free 800-977-0027 and follow the instructions given.

The *claims administrator* has made arrangements with an independent company to make MedCall available to you as a special service. It may be discontinued without notice.

Note: MedCall is an optional service. Remember, the best place to go for medical care is your *physician*.

Claims Administered by:

BLUE CROSS OF CALIFORNIA

on behalf of

BC LIFE & HEALTH INSURANCE COMPANY

TABLE OF CONTENTS

TYPES OF PROVIDERS	1
SUMMARY OF BENEFITS	3
MEDICAL BENEFITS.....	4
YOUR MEDICAL BENEFITS	12
HOW COVERED EXPENSE IS DETERMINED	12
DEDUCTIBLES, CO-PAYMENTS, NON-CERTIFICATION PENALTY, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS	13
CONDITIONS OF COVERAGE	15
MEDICAL CARE THAT IS COVERED	16
MEDICAL CARE THAT IS NOT COVERED.....	30
PRE-EXISTING CONDITION EXCLUSION	35
REIMBURSEMENT FOR ACTS OF THIRD PARTIES	36
COORDINATION OF BENEFITS	36
BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES	40
MEDICAL MANAGEMENT PROGRAMS	41
UTILIZATION REVIEW PROGRAM	41
AUTHORIZATION PROGRAM	45
THE MEDICAL NECESSITY REVIEW PROCESS	50
PERSONAL CASE MANAGEMENT	52
DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS.....	53
QUALITY ASSURANCE	54
HOW COVERAGE BEGINS AND ENDS	54
HOW COVERAGE BEGINS	54
HOW COVERAGE ENDS	57
CONTINUATION OF COVERAGE	60
COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES	63
GENERAL PROVISIONS	63
BINDING ARBITRATION	68

DEFINITIONS69
FOR YOUR INFORMATION.....81
PLAN INFORMATION82

Dear Plan Beneficiary:

This Summary Plan Description provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Employees and covered dependents (“beneficiaries”) are referred to in this booklet as “you” and “your”. The *plan administrator* is referred to as “we”, “us” and “our”.

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Summary Plan Description (“*plan description*”) carefully so that you understand all the benefits your *plan* offers. Keep this Summary Plan Description handy in case you have any questions about your coverage.

Note: BC Life & Health Insurance Company, the *claims administrator*, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BC Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers. The *plan* has made available to the *beneficiaries* a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called the Prudent Buyer Plan. They have agreed to provide our *beneficiaries* with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We will provide you with a directory of participating providers upon request. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities, physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call the *claims administrator* at the customer service number listed on your ID card and ask the *claims administrator* to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on the *claims administrator's* website at www.bluecrossca.com.

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of the Prudent Buyer Plan provider network.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your *dependent* might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call the claims administrator at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Contracting and Non-Contracting Hospitals. Another type of provider is the "contracting hospital". This is different from a *hospital* which is a *participating provider*. The *claims administrator* has contracted with most hospitals in California to obtain certain advantages for patients covered under the *plan*. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over 90%--accept. **For those which do not (called *non-contracting hospitals*), there is a significant benefit penalty in your *plan*.**

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Centers of Expertise. The *claims administrator* has established the following separate *Centers of Expertise* (COE) networks. The facilities included in each of these *COE* networks provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Subject to any applicable co-payments or deductibles, these *COE's* agree to accept the *COE negotiated rate* as payment in full for covered services. **These procedures are covered only at a COE.**
- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only at a COE.**

A *participating provider* in the Prudent Buyer Plan network is not necessarily a *COE* facility.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED TO BE MEDICALLY NECESSARY AS DEFINED IN THE PLAN DESCRIPTION. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS A COVERED EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire *plan description* for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this <i>plan</i> are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
--

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Individual Deductible **\$250**
- Family Deductible **\$750**

Exceptions: In certain circumstances, one or more of these Deductibles may not apply, as described below:

- The Calendar Year Deductible will not apply to the following services provided by a *participating* or *non-participating provider*: (a) *physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; and (b) Routine Physical Exams under the Preventive Care Benefits.

- The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating* or *non-participating provider*, if those visits are for treatment for other than *mental or nervous disorders* or substance abuse.

Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

- The Calendar Year Deductible will not apply to *covered expense* incurred for:
 - a. Physical therapy;
 - b. Speech therapy;
 - c. Ambulance services; and
 - d. *Emergency* and non-emergency services provided in a *hospital* emergency room.
- The Calendar Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.
- The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at an approved COE.

NON-CERTIFICATION PENALTY

- Non-Certification Penalty applicable to ALL inpatient admissions when pre-certification is not performed**20%**

Exception: The Non-Certification Penalty will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider*. See MEDICAL MANAGEMENT PROGRAMS: UTILIZATION REVIEW PROGRAM. See page 15 which describe this penalty and your co-payment.

CO-PAYMENTS

You will be responsible for the following dollar co-payment per visit (if applicable) and/or the applicable percentage co-payment for *covered expense* you incur:

DOLLAR CO-PAYMENTS

- *Physicians* Office Visit Charges (except for routine physical exams for *beneficiaries* age 7 or over).....**\$25**

Note: This only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

- **Well Baby Care** for *beneficiaries* under age 7 (as described on page 25) (*Participating and Non-Participating Providers*)**\$25**
- Immunizations for covered *children*.....**\$25**
- Physical Therapy and Speech Therapy**\$25**
- Emergency and Non-Emergency Room Services.....**\$35**
- Ambulance Services (per trip)**\$35**

PERCENTAGE CO-PAYMENTS. You will be responsible for the following percentage co-payment after subtracting any applicable dollar co-payment.

- **Physician Office Visits** (*Participating and Non-Participating Providers*)**20%**
- **Non-emergency use of emergency room** (*Participating and Non-Participating Providers*)**30%**
- **Emergency room services** (*Participating and Non-Participating Providers*)**No Charge**

- **X-Ray and Laboratory services**
for other than routine pap smears and mammograms
(Participating and Non-Participating Providers)20%
 - **Home Health Care**
(Participating and Non-Participating Providers)20%
 - **Physical Therapy and Speech Therapy**
(Participating and Non-Participating Providers)20%
 - **Well Baby Care** for beneficiaries under age 7 as described on page
25 (Participating and Non-Participating Providers)20%
 - **Immunizations** for children as described on page 25
(Participating and Non-Participating Providers)No Charge
 - **Preventive Care** for beneficiaries age 7 and over as described on
page 25 (Participating and Non-Participating Providers) ...No Charge
 - **Routine Pap Smears or Routine Mammograms** (as described on
page 26)
(Participating and Non-Participating Providers)No Charge
 - **Mental or Nervous Disorders and Substance Abuse**
(Inpatient Hospital Care for Participating and
Non-Participating Providers)20%
- *Inpatient hospital for Substance Abuse is covered only during the acute phase of detoxification only.
- **Mental or Nervous Disorders**
(1st through 10th outpatient physician visit for Participating and
Non-Participating providers)No Charge

All Services Other Than Those Previously Listed

- **Participating Providers**20%
- **Other Health Care Providers** (This includes: certified RN
anesthetists, blood banks, ambulance companies & hospices)....20%
- **Non-Participating Providers***40%

Note: In addition to the Co-Payment shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or a *non-participating provider*.

***Exceptions:**

- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You will be responsible for charges which exceed *customary and reasonable charge* or *reasonable charge*.
 - a. *Emergency services* provided by other than a *hospital*;
 - b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Co-Payment will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in the *claims administrator's* judgment, cannot be safely moved);
 - c. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* (see MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM); or
 - d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist).
 - e. Cancer Clinical Trials.
- Your Co-Payment for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) authorized by the *claims administrator* and performed at a designated *COE* will be the same as for *participating providers*. **Services for specified organ transplants are not covered when performed at other than a designated COE.** See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM.
- No Co-Payment will be required for the transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM.
- Your Co-Payment for bariatric surgical procedures authorized by *claims administrator* and performed at a designated *COE* will be the same as for *participating providers*. **Services for bariatric surgical procedures are not covered when performed at other than a designated COE.** See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

NOTE: Co-Payments do not apply for bariatric travel expenses authorized by the *claims administrator*. Bariatric travel expense is available when the closest *COE* is in excess of 50 miles from the *beneficiary's* residence.

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for *covered expense* you incur during a *calendar year*, you will no longer be required to pay a Percentage Co-Payment for the remainder of that *year*, but you remain responsible for costs in excess of *covered expense*.

Per Individual:

- *Participating providers and other health care providers*..... \$ **3,000**
- *Non-participating providers* \$ **6,000**

Per Family:

- *Participating providers and other health care providers*..... \$ **6,000**
- *Non-participating providers* \$ **12,000**

***Exceptions:**

- Any Dollar Co-Payments per visit that you make will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Dollar Co-Payment for such care even after you have reached that amount.
- Expense which is applied toward any penalty, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.
- Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

MEDICAL BENEFIT MAXIMUMS

The *plan* will pay for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Home Health Care

- For covered home health services **65 visits**
per calendar year

Ambulatory Surgical Center

- For all covered services and supplies **\$350***
**Non-participating providers only*

Preventive Care

- For all *beneficiaries* age 7 and over: Covered office visits and x-ray and lab services for other than routine pap smears or mammograms (*participating provider* and *non-participating providers*) **\$250**
per calendar year*

*Note: Immunizations for *children* are not applied to the \$250 maximum.

Mental or Nervous Disorders

- For covered outpatient *physician's* services **10**
visits per calendar year
- For covered inpatient care **30**
days per calendar year

Physical Therapy and Physical Medicine

- For covered outpatient services **40**
visits per calendar year

Speech Therapy

- For covered outpatient services **40**
visits per calendar year

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
 - For transportation to the COE..... **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room,
double occupancy
 - For expenses such as meals **\$25**
per day for each person,
for up to 21 days per trip
- For the Donor per Transplant Episode limited to one trip per episode)
 - For transportation to the COE..... **\$250**
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 7 days
 - For expenses such as meals **\$25**
per day, up to 7 days

Bariatric Travel Expense

- For the *beneficiary* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
 - For transportation to the COE..... up to **\$130**
per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
 - For transportation to the COE..... up to **\$130**
per trip

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

The *plan* will pay for *covered expense* you incur. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and COE. The maximum *covered expense* for services provided by a *participating provider* or *COE* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* and *COE* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider*, you will not be responsible for any amount in excess of the *negotiated rate*. If you receive an authorized, specified organ transplant at a *COE*, you will not be responsible for any amount in excess of the *COE negotiated rate* for the covered services of a *COE*.

If you go to a *hospital* which is a *participating provider*, you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider*, you should request that all your provider services (such as services by an anesthesiologist) be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center*. An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Non-Participating Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* will always be the lesser of the billed charge or (1) for a *physician*, the *customary and reasonable charge* or (2) for other than a *physician*, the *reasonable charge*. You will be responsible for any billed charge which exceeds the *customary and reasonable charge* or the *reasonable charge*.

The maximum *covered expense* for *non-participating providers* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital*, in excess of the approved amount as determined by Medicare; or
2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* stated above, or the approved amount as determined by Medicare; or
4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the maximum *covered expense* stated above, or the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this *plan*.

DEDUCTIBLES, CO-PAYMENTS, NON-CERTIFICATION PENALTY, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable Deductible Dollar and/or Percentage Co-Payment and your Co-Payment, benefits will be paid up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only charges that are considered *covered expense* will apply toward satisfaction of any deductible.

Calendar Year Deductibles. Each *year*, you will be responsible for satisfying the Individual Calendar Year Deductible before the *plan* begins to pay benefits. If members of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.

CO-PAYMENTS

After you have satisfied any applicable deductible, your Co-Payment will be subtracted from the amount of *covered expense* remaining.

Before the Percentage Co-Payment is applied, any applicable Dollar Co-Payment will first be deducted and then the applicable percentage will be applied to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your total Co-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If after you have met your Calendar Year Deductible, you pay Percentage Co-Payments equal to your Out-of-Pocket Amount during a *calendar year*, you will no longer be required to make any Percentage Co-Payments for any *covered expense* you incur during the remainder of that *year*. Dollar Co-Payments will continue to apply to covered services after the Out-of-Pocket amount has been satisfied.

Participating Providers and Other Health Care Providers. Only *covered expense* for the services of a *participating provider* or *other health care provider* will be applied to the *participating provider* and *other health care provider* Out-of-Pocket Amount.

After this Out-of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to make any Percentage Co-Payment for the covered services provided by a *participating provider* or *other health care provider* for the remainder of that *year*.

Non-Participating Providers. Only *covered expense* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to make any Percentage Co-Payment for the covered services provided by a *non-participating provider* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The following charges will not be applied toward satisfaction of the Out-of-Pocket Amount:

- Charges which are not considered *covered expense*;
- Any expense applied to the non-certification penalty;
- Any expense applied to a deductible;
- Dollar Co-payments for services listed in the SUMMARY OF BENEFITS.

In addition, you will continue to be required to pay your Dollar Co-Payment for services listed in the SUMMARY OF BENEFITS even after the Out-of-Pocket Amount is reached.

Prior Plan Out-of-Pocket Amounts. If you were covered under the *prior plan*, any amount applied during the same *calendar year* toward your out-of-pocket amount under the *prior plan* will be applied toward your Out-of-Pocket Amount under this *plan*.

NON-CERTIFICATION PENALTY

Each time you are admitted to a *hospital* or *residential treatment* center without properly obtaining certification, you are responsible for paying the Non-Certification Penalty. This penalty will not apply to an *emergency* admission or procedure, nor to services provided at a *participating provider*. Certification is explained in MEDICAL MANAGEMENT PROGRAMS: UTILIZATION REVIEW PROGRAM.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *beneficiary* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits paid to you on your behalf under any other health plan we provide.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

6. Any services received must be those which are regularly provided and billed by the *provider*. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between the *claims administrator* and the *hospital*, or unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. For the purpose of care provided for the treatment of *severe mental disorders* or substance abuse, the term "skilled nursing facility" includes *residential treatment center*.

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.

Note: *Facility-based care* for the treatment of substance abuse is limited to 30 days per *calendar year*. Any days you spend as an inpatient in a *residential treatment center* will be counted against this 30 day limit.

Home Health Care. The following services provided by a *home health agency*:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by the *home health agency*.

In no event will benefits exceed 65 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to the *claims administrator*. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *employee's* or the *dependent's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to us every 30 days.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

For the services of a *non-participating provider* facility only, our maximum payment is limited to **\$350** each time you have outpatient surgery at an *ambulatory surgical center*.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an *emergency* medical condition that requires an emergency response, please call the “911” emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. The *plan* will pay for other *medically necessary prosthetic devices* including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes; and
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

Pediatric Asthma Equipment and Supplies. The following items and services when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *beneficiary* is less than seven years old, (b) the *beneficiary* is developmentally disabled, or (c) the *beneficiary's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

4. **Bony Impacted Wisdom Teeth.** Services of an oral surgeon for the extraction of bony impacted wisdom teeth.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is a *employee*, enrolled *spouse* or enrolled *domestic partner*.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The organ or tissue recipient; or
2. The organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not an enrolled *beneficiary* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining our prior authorization, or which are provided at a facility other than a transplant center approved by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

You must obtain the *claims administrator's* prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to preoperative tests and postoperative care. Specified organ transplants must be performed at a *Center of Expertise (COE)*. **Charges for services provided for or in connection with a specified organ transplant performed at a facility other than a COE will not be considered covered expense.** See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for details.

Transplant Travel Expense. The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a *COE*, provided the expenses are authorized by the *claims administrator* (See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for details.):

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
 - a. Round trip coach airfare to the *COE*, not to exceed **\$250** per person per trip.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 21 days per trip, limited to one room, double occupancy.
 - c. Other expenses, such as meals, not to exceed **\$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
 - a. Round trip coach airfare to the *COE*, not to exceed **\$250**.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 7 days.
 - c. Other expenses, such as meals, not to exceed **\$25** per day, for up to 7 days.

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at an approved *COE* facility. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

You must obtain prior authorization for all bariatric surgical procedures.

Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *COE* will not be considered covered expense.

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the *beneficiary's* home is fifty (50) miles or more from the nearest bariatric *COE*. All travel expenses must be approved by the claims administrator in advance. The fifty (50) mile radius around the *COE* will be determined by the *bariatric COE coverage area*. (See DEFINITIONS.)

- Transportation for the *beneficiary* to and from the *COE* up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).

- Transportation for one companion to and from the *COE* up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *beneficiary* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *beneficiary's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric *COE*. Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Mental or Nervous Disorders. Covered services shown below for the treatment of *mental or nervous disorders*, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of MEDICAL CARE THAT IS COVERED and services from a residential treatment center, limited to a maximum of **30** days per *calendar year*.
2. *Physician's* visits during a covered inpatient *stay* or for outpatient psychotherapy or psychological testing. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders*. Outpatient *physicians* visits are limited to **10** visits per *calendar year*.

The combined maximum for inpatient *hospital* and *residential treatment center* services and visits to a *day treatment center* will be 30 days during a *calendar year*.

If *covered expense* is applied towards the *Calendar Year* Deductible, and payment is not provided, that visit is not included in the visit maximum (10 visits) for that *year*. However, if any portion of your *covered expense* is paid for a visit, that visit is included in the visit maximum.

Covered services for the treatment of *severe mental disorders* will not be subject to any limitations applicable to *mental or nervous disorders* shown in the SUMMARY OF BENEFITS or under these "Mental or Nervous Disorders or Substance Abuse" provisions. Such services will be subject to all other terms, conditions, limitations and exclusions, including applicable Medical Benefit Maximums. Please refer to the DEFINITIONS section for a description of "severe mental disorders".

Substance Abuse. Services for the short term, acute care treatment of substance abuse. These services must offer a reasonable expectation of improvement, and be provided at the lowest level of care consistent with safe medical practice. We will pay for covered services for inpatient *hospital* services as stated in the "Hospital" provision of MEDICAL CARE THAT IS COVERED for detoxification only during the acute phase substance abuse.

Well Baby and Well Child Care. The following services for a dependent *child* under 7 years of age:

1. A *physician's* services for routine physical examinations. (The **\$25** *physician* office visit co-payment as well as the percentage co-payment shown in the SUMMARY OF BENEFITS will apply to these services.)
2. Immunizations given as standard medical practice for *children*. You will have to pay a **\$25** co-payment for each immunization given by a *participating* or *non-participating provider*.
3. Radiology and laboratory services in connection with routine physical examinations.

Preventive Care. The following services will be provided for *beneficiaries* age 7 and over up to a maximum payment of **\$250** per *calendar year* (immunizations for *children* are not included in the **\$250** maximum):

1. A *physician's* services for routine physical examinations. (The **\$25** *physician* office visit co-payment will NOT apply to these services.)
2. Immunizations given as standard medical practice for *children*. You will have to pay a **\$25** co-payment for each immunization given by a *participating* or *non-participating provider*.
3. Radiology and laboratory services in connection with routine physical examinations other than for routine pap smears or mammograms.

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*.

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Sterilization. Sterilization of males and females including vasectomies and tubal legations.

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.

3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *beneficiary*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *beneficiaries* enrolled in the trial.

For payment for *non-participating providers*, the cost will be based on the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Coverage for clinical trials is restricted to *participating providers* in the state of California unless the protocol for the clinical trial is not provided for at a California *hospital* or by a California *physician*.

Physical Therapy and Physical Medicine. The following services provided by a *physician* under a treatment plan which offers a reasonable expectation of significant improvement:

Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths.)

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Up to a combined maximum of **40** visits in a *year* for all covered services are payable.

But, if the *claims administrator* determines that an additional period of physical therapy or physical medicine is both *medically necessary* and likely to result in a significant improvement to your condition by measurably reducing your physical impairment during that period of additional care, the *claims administrator* will authorize a specific number of additional visits.

Such additional visits are not payable if prior authorization is not obtained. (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.)

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease up to a maximum of **40** visits per *calendar year*.

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:
 - a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
 - b. Insulin pumps.
 - c. Pen delivery systems for insulin administration (non-disposable).
 - d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.
 - e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

2. Diabetes education program which:
 - a. Is designed to teach a *beneficiary* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *beneficiary* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.

Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following items are covered as medical supplies:
 - a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
 - b. Testing strips, lancets, and alcohol swabs.

Allergy. Allergy testing and *physician's* services.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

Jaw Joint Disorders. The *plan* will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with *urgent care* or an *emergency*.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before your *effective date* or after your coverage ends.

Excess Amounts. Any amounts in excess of *covered expense* or the Lifetime Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *beneficiary* and a provider, for which reimbursement under the *Medicare* program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental or Nervous Disorders" or "Substance Abuse" provisions of MEDICAL CARE THAT IS COVERED.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth (except for surgical services for the removal of bony impacted wisdom teeth), or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Preventive Care (Beneficiaries Age 7 and Over)" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice or home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered, as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the treatment of infertility, including, but not limited to, medications, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Elective Abortions. Elective abortions, unless the life of the mother is endangered by the continuation of pregnancy.

Surrogacy. Any services or supplies provided in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specifically provided or arranged by us, or as stated under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED. Food or dietary supplements, except as specifically stated under the "Special Food Products" provision of MEDICAL CARE THAT IS COVERED.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Preventive Care", "Cervical Cancer Screening", "Breast Cancer", "Prostate Cancer Screening", or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

Acupuncture. Acupuncture treatment. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Physical Therapy and Physical Medicine" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in "Injectable Drugs and Implants for Birth Control" provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Cancer Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.

PRE-EXISTING CONDITION EXCLUSION

No payment will be made for services or supplies for the treatment of a *pre-existing condition*. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your coverage under this *plan*. Generally, this six-month period ends the day before your coverage becomes effective. However if you were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The *pre-existing condition* exclusion does not apply to pregnancy.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior *creditable coverage*. Most prior health coverage is *creditable coverage* and can be used to reduce the *pre-existing condition* exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the six-month exclusion period by your *creditable coverage*, you should give us a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have *creditable coverage*. Please contact us if you need help demonstrating *creditable coverage*. All questions about the *pre-existing condition* exclusion and *creditable coverage* should be directed to the customer service telephone number listed on your identification card.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *beneficiary* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable, but, not more than the amount allowed by California Civil Code Section 3040.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.
3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each *beneficiary*, per *calendar year*. Any coverage you have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as an *employee* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired *employee*.

For example: You are covered as a retired *employee* under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired *employee* would pay last.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *calendar year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
- b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.

- iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
 5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
 6. If a *beneficiary* has dental coverage which provides benefits for surgical services related to the removal of bony impacted wisdom teeth.
 7. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

For Active Employees and Dependents. If you are a *full-time employee* or a *dependent* of a *full-time employee*, and entitled to Medicare, you will receive the full benefits of this *plan*, except as listed below:

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or
2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a group of 100 or more employees (according to federal OBRA legislation).

In cases where exceptions 1 or 2 apply, payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

For Retired Employees and Their Spouses. If you are a *retired employee* or the spouse of a *retired employee* and you are eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

Coordinating Benefits With Medicare. The *plan* will not provide benefits under this *plan* that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this *plan* except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.

2. For services you receive that are covered both by Medicare and under this *plan*, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not exceed *covered expense* for the covered services.

The *plan* will apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any.

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to inpatient *hospital* and *residential treatment center* admissions, outpatient surgery at an *ambulatory surgical center*, and *facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

<p>Important: Medical management requirements described in this section do not apply when coverage under this <i>plan</i> is secondary to another plan providing benefits for you or your <i>dependents</i>.</p>

UTILIZATION REVIEW PROGRAM

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by the *claims administrator* and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of UTILIZATION REVIEW PROGRAM.

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions;
- Outpatient surgery at an *ambulatory surgical center*, and
- *Facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency inpatient *hospital* and *residential treatment center* admissions, *ambulatory surgical center* services, and *facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or the *claims administrator* is notified while service is ongoing, for example, an emergency admission to the hospital.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-authorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* or *residential treatment center* admission, an outpatient surgical procedure at an *ambulatory surgical center*, or for *facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.
2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. *Facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse will be provided only when the type and level of care requested is *medically necessary* and appropriate for your condition. If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.
3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed.

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* directly. The toll-free number for Pre-authorization and pre-service review is printed on your identification card.
3. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. For *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders*, and substance abuse, the *claims administrator* will, if appropriate, certify the type and level of services, as well as their duration. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.
2. When *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. If you have an *authorized referral* to a *non-participating provider*, you may ask that *non-participating provider* to call the toll-free number printed on your identification card, or you may call directly.
3. When it is determined that the service is *medically necessary* and appropriate, the *claims administrator* will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.
4. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. The *claims administrator* will send written notice to you and your *physician* within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

***Extraordinary Circumstances.** In determining "extraordinary circumstances", the *claims administrator* may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify the *claims administrator* for you. You may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrator* is not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified. It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.
2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

AUTHORIZATION PROGRAM

The authorization program provides prior authorization for medical care or service by a *non-participating provider*, and for certain "special services".

It is your responsibility to obtain authorization before you receive any service subject to the authorization program. The toll-free number to call for authorization is shown on your plan identification card.

If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits" portion of AUTHORIZATION PROGRAM.

SERVICES REQUIRING AUTHORIZATION

Authorized Referrals. In order for the maximum benefits of this *plan* to be payable, advance authorization is required for services received from *non-participating providers*. When the appropriate authorization is obtained, these services are called *authorized referral* services.

NOTE: *Authorized referrals* are not required for the services of *physicians* of a type not available with the Prudent Buyer Plan network. A *physician's* written referral is required, however, in order for the services of some *physicians* to be covered under this *plan*. Refer to the definition of "Physician" in the DEFINITIONS section.

Special Services

1. Organ and tissue transplants.
2. Travel expense benefits.
3. Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine, Chiropractic Care and Acupuncture" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
4. Home infusion therapy.
5. Home health care.
6. Admissions to a *skilled nursing facility*.
7. Bariatric surgical services performed at a *Centers of Expertise*.

EFFECT ON BENEFITS

For Services Requiring Authorized Referral

1. The Percentage Co-Payment for *participating providers* will apply for *medically necessary authorized referral* services received from a *non-participating provider*.
2. The Percentage Co-Payment for *non-participating providers* will apply for referral services received from *non-participating providers* that have not been authorized in advance.

For Special Services. Benefits for special services subject to prior authorization will be provided as stated in this *plan* for the specific service only when authorization has been obtained as required. No benefits are payable for unauthorized special services.

WHEN AUTHORIZATION WILL BE PROVIDED

Authorized Referrals. Referrals to *non-participating providers* will be authorized only when all of the following criteria are met:

1. There is no *participating provider* who practices the appropriate specialty or provides the required services or has the necessary facilities within a 30-mile radius of, or 30 minutes normal travel time from, your residence or place of work;
2. You are referred to the *non-participating provider* by a *physician* who is a *participating provider*; and
3. The services are authorized as *medically necessary* before services are received.

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a bariatric *COE*.

Special Services

1. **Organ and Tissue Transplants.** Authorizations for organ and tissue transplants will be provided as follows:
 - a. For kidney, bone, skin or cornea transplants, only if both of the following criteria are met:
 - i. The services are *medically necessary* and appropriate; and
 - ii. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, only if all of the following criteria are met:
 - i. The services are *medically necessary* and appropriate;
 - ii. The providers of related preoperative and postoperative services are approved; and
 - iii. The transplant will be performed at a *Center of Excellence (COE)*.

2. **Transplant Travel Expense Benefits.** Authorizations for transplant travel expense benefits will be provided for the recipient or donor only if all of the following criteria are met:
 - a. It is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, authorized by the *claims administrator*;
 - b. The organ transplant must be performed at a specific COE; and
 - c. The specific COE is 250 miles or more from the recipient or donor's home.
3. **Physical Therapy, Physical Medicine and Occupational Therapy.** The number of visits for physical therapy, physical medicine and occupational therapy which are payable without prior authorization is stated in the "Physical Therapy, Physical Medicine or Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specific number of additional visits will be authorized when:
 - a. Additional visits are *medically necessary* and appropriate and likely to result in a significant improvement in your condition.
 - b. You or your *physician* requests approval for the additional benefits prior to those services being rendered.
4. **Home Infusion Therapy.** Authorizations for services by a *home infusion therapy provider* will be provided only if the following criteria are met:
 - a. The services are *medically necessary* and appropriate; and
 - b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services being rendered.
5. **Home Health Care.** Authorizations for home health care services will be provided only if the following criteria are met:
 - a. The services are *medically necessary* and appropriate and can be safely provided in the *beneficiary's* home, as certified by the attending *physician*.
 - b. The attending *physician* manages and directs the *beneficiary's* medical care at home.

c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *beneficiary's* medical needs and must list the services to be provided by the *home health agency*.

6. **Skilled Nursing Facility.** The *claims administrator* will authorize inpatient services provided in a *skilled nursing facility* if:

- a. You require daily skilled nursing or rehabilitation, as certified by the attending *physician*;
- b. You were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and
- c. You will be treated for the same condition for which you were treated in the *hospital*.

Note: Admissions to a *residential treatment center* will not be subject to the authorization program. They are instead subject to the utilization review program (see UTILIZATION REVIEW PROGRAM).

7. **Bariatric Surgery.** Authorization for all bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss is required. These are the conditions that have to be met in order for these services to be covered:

- a. The services are *medically necessary* and appropriate; and
- b. The services are to be performed for the treatment of morbid obesity; and
- c. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
- d. The bariatric surgical procedure will be performed at a *Centers of Expertise (COE)*.

HOW TO OBTAIN AN AUTHORIZATION

For Authorized Referrals. You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

For Special Services Authorizations. You or your *physician* must call the toll-free telephone number printed on your identification card before the services are rendered.

THE MEDICAL NECESSITY REVIEW PROCESS

The *claims administrator* will work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, the *claims administrator* is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 2 business days from receipt of the information necessary to make the decision.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information necessary to make the decision.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision.
4. If the *claims administrator* does not have the information needed, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service certified as *medically necessary* will be sent to you and your provider no later than 2 business days after the decision.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,
 - reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The *claims administrator*, through a case manager, may recommend an alternative plan of treatment which may include services not covered under this *plan*. The *plan administrator* does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or the *claims administrator's* claims reports. You or your family may also call the *claims administrator*.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. The *claims administrator* anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If the *claims administrator* determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this *plan*. A case manager will review the medical records and discuss your treatment with the attending *physician*, you, and your family.

The *claims administrator* makes treatment recommendations only; any decision regarding treatment belongs to you and your *physician*. The *plan* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward the Lifetime Maximum.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *plan administrator and claims administrator* have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *beneficiary*, which alternatives may be offered and the terms of the offer.
3. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *beneficiary*.
4. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *beneficiary*.

Note: The *claims administrator* reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to the *claims administrator*.
3. If the appeal decision is still unsatisfactory, your remedy is binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Medical management programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. The *claims administrator's* Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Employee.** You are eligible to enroll as an *employee* if you are a retired *employee* who is entitled to Part A or actively enrolled in Part B of *Medicare*.
2. **Dependent.** The *employee's spouse* or *domestic partner* is eligible to be enrolled as a *dependent*, provided that the *spouse* or *domestic partner* is entitled to Part A or actively enrolled in Part B of *Medicare*. *Spouse* is the *employee's spouse* under a legally valid marriage between persons of the opposite sex. *Domestic partner* is the *employee's domestic partner* under a legally registered and valid domestic partnership. *Spouse* or *domestic partner* does not include any person who is covered as an *employee*.

ELIGIBILITY DATE

1. For *employees*, you become eligible for coverage on the first day of the month coinciding with or following your date of hire. (This is your "waiting" period.)
2. For *dependents*, you become eligible for coverage on the later of:
(a) the date the *employee* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

ENROLLMENT

To enroll as an *employee*, or to enroll *dependents*, the *employee* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 31 days from your eligibility date. If this step is not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *employees*, on your eligibility date; and (b) for *dependents*, on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible.
If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan*, provided the enrollment application is on time and in order.
2. **Late Enrollment:** If you enroll more than 31 days after your eligibility date, you must wait until the next Open Enrollment Period to enroll.
3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

SPECIAL ENROLLMENT PERIODS

You may enroll without waiting for the next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
 - b. Your coverage under the other health plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no share-of-cost Medi-Cal coverage. Loss of eligibility under another plan does not include a loss due to: failure to pay required monthly contributions when due; failure to exhaust COBRA continuation coverage, if elected; or causes such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the *plan*.
 - c. You properly file an application with the *plan administrator* within 31 days from the date on which you lose coverage. Coverage will be effective on the first of the month following the date you file the enrollment application.
2. A court has ordered coverage be provided for a *spouse* or *domestic partner* under your employee health plan and an application is filed within 31 days from the date the court order is issued or is filed within the period required by law. Coverage will be effective on the first of the month following the date you file the enrollment application.
3. You have a change in family status through marriage or establishment of a domestic partnership. You may also enroll a new *spouse* or *domestic partner* at that time. You must enroll within 31 days of the date of the marriage or establishment of the domestic partnership. Coverage will be effective on the first day of the month following the date you file the enrollment application.

4. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

RIGHTS REGARDING A DIFFERENT PLAN

Subject to the special enrollment requirements, if you are enrolled in this *plan*, but your dependent declines coverage due to other coverage and then subsequently loses that other coverage, you and your dependent may both enroll in a different plan sponsored by the *plan administrator*.

Subject to the special enrollment requirements, if you enrolled in this *plan* and subsequently obtain a new eligible dependent, both you and your dependent may enroll in a different plan sponsored by the *plan administrator*.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*, between May 1st and June 15th. During that time, an individual who meets the eligibility requirements as an *employee* or *dependent* under this *plan*, may enroll. An *employee* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the *plan* terminates, your coverage ends at the same time. This *plan* may be canceled or changed without notice to you.
2. If the *plan* no longer provides coverage for the class of *beneficiaries* to which you belong, your coverage ends on the effective date of that change. If this *plan* is amended to delete coverage for *dependents*, a *dependent's* coverage ends on the effective date of that change.
3. Coverage for *dependents* ends when *employee's* coverage ends.
4. Coverage ends at the end of the month in which required monthly contributions cease.

5. If you voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which you provide to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends at the end of the month in which you are no longer eligible to participate in the *plan*.

Exception to item 6:

Leave of Absence. If you are an *employee* and the required monthly contributions are paid, your coverage may continue: (i) for up to six months during a temporary leave of absence; (ii) for up to twelve months during a sabbatical year's leave of absence; or (iii) for the duration of an extended leave of absence due to illness certified annually by the *plan administrator*.

7. A *beneficiary's plan* coverage or eligibility for coverage may be terminated if:
 - a. The *beneficiary* submits any claim that contains false or fraudulent elements under state or federal law;
 - b. A civil or criminal court finds that the *beneficiary* has submitted claims that contain false or fraudulent elements under state or federal law;
 - c. A *beneficiary* has submitted a claim that, in good faith judgment and investigation, he or she knew or should have known, contained false or fraudulent elements under state or federal law.

Note: If a marriage or domestic partnership terminates, the *employee* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partner*, if any, ends according to the "Eligible Status" provisions. If the *plan administrator* suffers a loss because of the *employee* failing to notify the *group* of the termination of their marriage or domestic partnership, Blue Cross may seek recovery from the *employee* for any actual loss resulting thereby. Failure to provide written notice to the *plan administrator* will not delay or prevent termination of the marriage or domestic partnership. If the *employee* notifies the *plan administrator* in writing to cancel coverage for a former *spouse* or *domestic partner*, if any, immediately upon termination of the *employee's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE and COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *plan* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your employer for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

Qualified Beneficiary means a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either an *employee* or enrolled *spouse*. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including a *spouse* acquired during the COBRA continuation period. It does not include *domestic partners* if they are eligible under HOW COVERAGE BEGINS AND ENDS.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the *plan*. The events will be referred to throughout this section by number.

1. **For Retired Employees and the Spouse.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *plan administrator's* filing for Chapter 11 bankruptcy, provided that:
 - a. The *plan* expressly includes coverage for retirees; and
 - b. Such cancellation or reduction of benefits occurs within one year before or after the *plan administrator's* filing for bankruptcy.
2. **For the Spouse:**
 - a. The death of the *employee*; or
 - b. The *spouse's* divorce or legal separation from the *employee*.

ELIGIBILITY FOR COBRA CONTINUATION

An *employee* or enrolled *spouse* may choose to continue coverage under the *plan* if coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *plan administrator* will notify either the *employee* or *spouse* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Event 1, the *plan administrator* will notify the *employee* of the right to continue coverage.
2. For Qualifying Events 2(a), the *spouse* will be notified of the COBRA continuation right.
3. You must inform the *plan administrator* within 60 days of date of loss of coverage due to Qualifying Events 2(b) above if you wish to continue coverage. The *plan administrator* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *plan administrator* within 60 days after the date that *plan* coverage is lost, or, if later, 60 days from the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for both the *employee* and *spouse*, or for the *employee* only, or for the *spouse* only.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to the *plan administrator* within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A *spouse* acquired during the COBRA continuation period is eligible to be enrolled as a dependent, provided that the *spouse* meets the eligibility requirements specified in HOW COVERAGE BEGINS. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Open Enrollment. You may change coverage or add a dependent *spouse* at open enrollment.

Cost of Coverage. The *plan administrator* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *plan administrator* each month during the COBRA continuation period.

Besides applying to the *employee*, the *employee's* rate also applies to a *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*.

Special Second Election Period for Certain Eligible Employees Who Did Not Elect COBRA. Certain employees and former employees who were eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after *plan* coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA, contact the *plan administrator* promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect COBRA during a special election period. Contact the *plan administrator* for more information about the special election period.

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the required monthly contribution is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For a *spouse* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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

1. The end of 36 months from the date of loss of coverage due to the Qualifying Event, if the Qualifying Event was the death of the *employee*, divorce or legal separation;*
2. The date the *plan* terminates;
3. The end of the period for which required monthly contributions charges are last paid;
4. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied.

*For a *beneficiary* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of loss of coverage due to the Qualifying Event under that *prior plan*.

Subject to the *plan* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 1 may be covered for the remainder of his or her life; that person's enrolled *spouse* may continue coverage for 36 months after the *employee's* death. But coverage could terminate prior to such time for either the *employee* or *spouse* in accordance with any of the items above.

COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES

If the *employee* dies while covered under this *plan* as a certificated active employee or a certificated retired employee, coverage continues for an enrolled spouse until one of the following occurs:

1. Required monthly contributions charges are not paid, or
2. The *plan* cancels coverage for the class of *employees* to which the *beneficiary* belongs, or
3. The *plan* terminates.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the employer provides to its employees or their *dependents*. You may be responsible for all or part of the subscription charges.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of *hospital*, medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor is *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital*, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which the *claims administrator* is a member, has a program (called the “BlueCard Program”) which allows our *beneficiaries* to have the reciprocal use of participating providers contracted under other states’ Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, we must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your co-payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”) passes on to the *claims administrator*.

Often, the “negotiated price,” referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers.

If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *beneficiary* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *beneficiary* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with the *claims administrator*. If you have any questions or complaints about the BlueCard Program, please call the *claims administrator* at the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan*, both the *plan* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without your consent or concurrence.

Free Choice of Provider. This *plan* in no way interferes with your right as a *beneficiary* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received.

You may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Continuity of Care. If the *claims administrator* terminates our contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination).

To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the *claims administrator* at the customer service telephone number listed on your ID card.

If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from the *claims administrator*, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *beneficiary* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must submit a request for payment of benefits within one year after the date you receive the service or supply for which the claim is made. If a provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not provide this information to us within one year of the date of the service or supply, benefits for that health service or supply will be denied or reduced, in our or the *claims administrator's* discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient *stay*, the date of service is the date your inpatient *stay* ends. Services received and charges for services must be itemized, and clearly and accurately described. Claim forms must be used; cancelled checks or receipts are not acceptable. Claims for services rendered in a foreign country should be presented in English and in U.S. dollars and cents.

Timely Payment of Claims. Any benefit due under this *plan* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonable necessary additional information the *claims administrator* may require to determine our obligation.

Payment to Providers. The benefits of this *plan* will be paid directly to *contracting hospitals, participating providers, COE* and medical transportation providers. Also, *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the *plan's* obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator - COBRA and ERISA. In no event will the *claims administrator* be *plan administrator* for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "*plan administrator*" refers to SHASTA-TRINITY SCHOOLS INSURANCE GROUP or to a person or entity other than the *claims administrator*, engaged by SHASTA-TRINITY SCHOOLS INSURANCE GROUP to perform or assist in performing administrative tasks in connection with the *plan*. The *plan administrator* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this *plan description*, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Workers' Compensation Insurance. The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided services and supplies to you, you will be required to pay that provider any amounts not paid to them by the *plan*.

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its members and *beneficiaries* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* or an affiliate is a party, including all persons covered under the *plan*.

Under the above-referenced contracts between Providers and *claims administrator* or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *plan* may differ from the rates paid for persons covered by other types of products or programs offered by the *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that the *claims administrator* or its affiliates offer several types of products and programs. The members, *beneficiaries* and *plan administrator* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by the *claims administrator* or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by the *claims administrator* or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by the *claims administrator* or an affiliate in determining its fees or subscription charges or premiums.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The *beneficiary* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *beneficiary* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *beneficiary* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *beneficiary*.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the *beneficiary* making written demand on the *plan administrator*. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures.

If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *beneficiary* and the *plan administrator*, or by order of the court, if the *beneficiary* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the beneficiary and the *plan administrator*.

DEFINITIONS

The meanings of key terms used in this booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this booklet, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, are referred to a *non-participating provider*, but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*, and
3. The referral has been authorized by the *claims administrator* before services are rendered.

Bariatric COE Coverage Area is the area within the 50-mile radius surrounding a designated Bariatric *COE*.

Beneficiary is the *employee* or *dependent*.

Centers of Expertise (COE) are health care providers which have a Centers of Expertise Agreement in effect with the claims administrator at the time services are rendered. *COE* transplant facilities agree to accept the *COE negotiated rate* as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a *COE*. A provider's participation in the Prudent Buyer Plan network or other agreement with the *claims administrator* is not a substitute for a Centers of Expertise Agreement.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to BC Life & Health Insurance Company. On behalf of BC Life & Health Insurance Company, Blue Cross of California shall perform all administrative services in connection with the processing of claims under the *plan*.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *beneficiaries*. A contracting hospital is not necessarily a *participating provider*. A list of contracting hospitals will be sent on request.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the *pre-existing condition* exclusion period under this *plan*.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan*).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by the *claims administrator*, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental or nervous disorders, severe mental disorders,* or substance abuse under the supervision of *physicians*.

Dependent meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *beneficiary* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Employee is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Facility-based care is care provided in a *hospital, psychiatric health facility, residential treatment center or day treatment center* for the treatment of *mental or nervous disorders, severe mental disorders,* or substance abuse.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations. Home infusion therapy providers are licensed to provide the *beneficiary* with intra-venous medications in the *beneficiary's* home.

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis.

A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care for the acute phase of a *mental or nervous disorder, severe mental disorder, or substance abuse*, "hospital" also includes *psychiatric health facilities*.

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically necessary procedures, supplies equipment or services are those the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and

5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Mental or nervous disorders, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (*e.g.*, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be; but medical conditions that are caused by your behavior that may be associated with these mental conditions (*e.g.*, self-inflicted injuries) and treatment for *severe mental disorders* are not subject to *plan* limitations that apply to mental or nervous disorders.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare's approved amount (see HOW COVERED EXPENSE IS DETERMINED).

Non-contracting hospital is a *hospital* which does not have a Standard Hospital Contract in effect with the *claims administrator* at the time services are rendered.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

Participating providers agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Pharmacy means a licensed retail pharmacy.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:
 - a. A dentist (D.D.S.)
 - b. An optometrist (O.D.)
 - c. A dispensing optician
 - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. A licensed clinical psychologist
 - f. A clinical social worker (L.C.S.W.)
 - g. A marriage and family therapist (M.F.T.)
 - h. A physical therapist (P.T. or R.P.T.)*
 - i. A speech pathologist*
 - j. An audiologist*
 - k. An occupational therapist (O.T.R.)*
 - l. A respiratory care practitioner (R.C.P.)*
 - m. A *psychiatric mental health nurse* (R.N.)*
 - n. A nurse midwife**
 - o. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

Plan administrator refers to SHASTA-TRINITY SCHOOLS INSURANCE GROUP, the entity which is responsible for the administration of the *plan*.

Plan description is this written description of the benefits provided under the *plan*.

Pre-existing condition means an illness, injury or condition which existed during the six-month period immediately prior to either (a) your *effective date* or (b) the first day of any waiting period required by the *plan administrator*, whichever is earlier. A condition is considered to have existed when you: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.

Prior plan is a plan sponsored by us which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reasonable charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Residential treatment center is an inpatient treatment facility where the *beneficiary* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental disorder, severe mental disorder,* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental disorders, severe mental disorders,* or rehabilitative treatment of substance abuse according to state and local laws.

Severe mental disorders include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

“Severe mental disorders” also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child’s* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Benefits for severe mental disorders will be provided according to the *plan’s* benefits for medical conditions, and will not be subject to *plan* provisions for *mental or nervous disorders*.

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare. For the purpose of care provided for the treatment of *mental or nervous disorders, severe mental disorders,* or substance abuse, the term “skilled nursing facility” includes *residential treatment center*.

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Totally disabled dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

Totally disabled employees are *employees* who, because of illness or injury, are unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Totally disabled retired employees are retired employees who are unable to perform all activities usual for persons of that age.

Transplant Centers of Expertise negotiated rate (COE negotiated rate) is the fee *COE* agree to accept as payment for covered services. It is usually lower than their normal charge. *COE* negotiated rates are determined by Centers of Expertise Agreements.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

We (us, our) refers to SHASTA-TRINITY SCHOOLS INSURANCE GROUP.

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *employee* and *dependent* who are enrolled for benefits under this *plan*.

FOR YOUR INFORMATION

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

PLAN INFORMATION

The following information, together with the preceding material, forms a summary plan description. The benefit plan description covers group medical coverage to eligible employees of SHASTA-TRINITY SCHOOLS INSURANCE GROUP. SHASTA-TRINITY SCHOOLS INSURANCE GROUP'S Group Medical Plan is administered on a self insured basis with benefit claims processed by Blue Cross of California, on behalf of BC Life & Health Insurance Company (Claims Administrator).

1. **Plan Name.** The designated name of the Plan is: SHASTA-TRINITY SCHOOLS INSURANCE GROUP.

2. **Plan Sponsor.** The name and address of the entity which established and maintains the Plan is:

Shasta-Trinity Schools Insurance Group
6724 Lockheed Drive, Suite 3A
Redding, Ca. 96002

3. **Plan Numbers:**

The Employer's Identification Number (EIN) is 68-0258745.

The Plan Number is 501.

4. **Type of Plan.** The Plan is an employee welfare benefit plan providing group medical benefits.

5. **Source of Plan Contributions.** The contributions necessary to finance the Plan are provided by the employer and the employees.

6. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on July 1st and ending on the following June 30th.

7. **Type of Administration/Funding.** Benefits are furnished under a health care plan funded by the Plan Sponsor. BC Life furnishes only certain claim processing and provider contracting services and has no financial responsibility for benefits.

BC Life's' address is:

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367

8. **Plan Administrator.** The name and address of the Plan Administrator is:

Shasta-Trinity Schools Insurance Group
6724 Lockheed Drive, Suite 3A
Redding, Ca. 96002

9. **Agent for Service of Legal Process.** The name and address of the designated agent for the service of legal process for the Plan is:

Shasta-Trinity Schools Insurance Group
6724 Lockheed Drive, Suite 3A
Redding, Ca. 96002

10. **Description of Benefits.** The Plan Description sets forth the benefits provided under this Plan. A brief explanation of these benefits may be found in the section entitled SUMMARY OF BENEFITS. A more detailed description of the benefits appears in the sections entitled YOUR MEDICAL BENEFITS; YOUR PRESCRIPTION DRUG BENEFITS.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

11. **Eligibility for Participation.** The eligibility requirements for participation under this Plan are set forth in the Plan Description in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.
12. **Grounds for Ineligibility or Loss or Denial of Benefits.** Details describing the circumstances which may result in: (a) disqualification from this Plan; (b) ineligibility for benefits; or (c) denial, loss, forfeiture or suspension of benefits under the Plan are set forth and identified in the Plan Description, as outlined below:
 - Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.
 - Benefits may be denied or suspended if statements a Plan participant has made in connection with obtaining coverage were false.
 - Information concerning situations under which benefits may be reduced or denied may also be found in the SUMMARY OF BENEFITS and DEFINITIONS sections and in the sections identified in the DESCRIPTION OF BENEFITS portion of this summary.
13. **Right to Amend or Terminate Plan.** The plan sponsor reserves the right to discontinue or change the Plan in any manner, at any time, for any reason, subject to any applicable legal requirement for prior notice.
14. **Plan is Not a Contract of Employment.** Nothing contained in this Plan will be construed as a contract or condition of employment between the employer and the employee. All employees are subject to discharge to the same extent as if this Plan had never been adopted.
15. **Claims Procedures.** The Plan Description contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or the Claims Administrator.

If your claim is denied in whole or in part, you will receive a notice of the denial. The notice will explain the reason for the denial.

You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request with the Claims Administrator for a review. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure. Your request for review must be filed within 60 days after the receipt of the written notice of denial of a claim. A decision will be rendered by the Claims Administrator normally within 30 days after the receipt of the request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall include specific reference to the pertinent benefit provisions of the Plan on which the decision is based.

An appeal of an adverse benefit decision is filed when submitted in writing to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060

The written appeal will be treated as received by the Plan on the date that it is deposited in the U.S. Mail for first class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

An appeal of an adverse benefit determination of an urgent care claim may also be made by phone. The phone number to call is 1-800-757-1256.

In making a decision regarding an appeal of an adverse benefit decision, Blue Cross of California may refer the claim to the Plan Administrator. Benefits under this Plan will be paid only if the Claims Administrator or Plan Administrator decides in their discretion that the applicant is entitled to them.

16. **HIPAA Privacy Statement.** A federal law—the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—imposes limits on how group health plans, carriers, and medical providers may use or disclose plan participants’ “protected health information” (PHI). It also gives individuals specified privacy rights, such as the right to access and copy their PHI that is held by health plans, carriers and providers, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. For a complete description of your rights under HIPAA, review the Plan’s separate Privacy Notice. You may have received more than one Privacy Notice if benefits under this Plan are provided by various carriers and/or are self-funded by the Plan.

It is the policy of this Plan and of the plan sponsor not to retaliate or discriminate against, or intimidate any participant who exercises his/her privacy rights. Nor will we require anyone to waive his/her privacy rights as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits.

Medical and dental benefits under this Plan are self-funded, which means that benefits are paid from the general assets of the plan sponsor and are not guaranteed by an insurance company. Plan participants will receive a Privacy Notice from the Plan. The Privacy Notice informs participants about how their PHI can be used or disclosed by the Plan, its “business associates” and the plan sponsor, and also provides information about individuals’ privacy rights. The plan has designated a “Privacy Official.” If you have any questions about the Plan’s Privacy Policy, please contact the Human Resources Department for information on how to contact the Privacy Official.

This Plan, and the plan sponsor, will not use or further disclose your PHI except pursuant to an Authorization Form signed by the patient, or as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.