

SAN DIEGO AND IMPERIAL COUNTY SCHOOLS
FRINGE BENEFITS CONSORTIUM
CONSORTIUM CUSTOM HEALTH BENEFITS PLAN
PREFERRED PROVIDER ORGANIZATION
PLAN DOCUMENT

San Diego and Imperial County Schools Fringe Benefits Consortium Custom Health Benefits Plan (hereafter called “The Plan”), a self-funded program, provides benefits of this “Plan Document,” as herein defined, for enrolled Members of the Fringe Benefits Consortium Health Benefits Program. These benefits are subject to all of the terms and conditions as set forth in this Plan Document.

The San Diego County Superintendent of Schools (hereafter called “the Superintendent”) administers the Plan. Among other things, the Superintendent is authorized by the San Diego and Imperial County Schools Fringe Benefits Consortium to enter into contracts on behalf of the Fringe Benefits Consortium, and the Superintendent, on behalf of the Plan Members, shall execute this Plan Document. The Plan is maintained for the exclusive benefit of Plan Members.

PLAN DOCUMENT DATE

The Plan Document becomes effective at 12:01 a.m. Pacific Standard Time on October 1, 1988. The Plan is established with the intention of being maintained for an indefinite period of time and remains in effect until cancelled. The Plan may be amended from time to time. Payment of the premium contribution charges indicates that the Plan Members accept this Plan Document.

Terms that are capitalized throughout this Plan Document are defined under DEFINITIONS. That section should be read carefully. Defined terms have the same meaning throughout the Plan Document.

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PART ONE: DEFINITIONS

When any of the following terms appear in the Plan Document with “initial” capital letters, they will have the meaning below:

- A. 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 illness or infection of a cut or wound that is a result of an Accidental Injury.
- B. An Allowable charge, as determined annually by The Plan, 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, or which is justified based on the complexity or the severity of treatment for a specific case.
- C. A Calendar Year is the twelve-month period starting each January 1 at 12:01 a.m. Pacific Standard Time.
- D. A Child is the Member’s biological child, stepchild, or legally adopted child. Additionally, a covered child is one for whom a covered employee has been appointed legal guardian and when the child lives with, and depends upon, the employee for care and support.
- E. A Claim is a fully itemized bill submitted by either the member or the provider of service. All Claims must fully itemize the services rendered, in English, using CPT, CRVS, or RBRVS codes. All Claims must be submitted on properly completed forms or universally completed forms. All Claims must be received by the Plan within 3 months, but never later than 12 months from the date services are rendered.
- F. COBRA is an acronym for Consolidated Omnibus Budget Reconciliation Act.
- G. Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance and/or is not Medically Necessary.
- H. Custodial Care is care provided primarily to meet the personal needs of the Member and/or that which does not require skilled medical personnel to perform. This includes, but is not limited to, help in getting in and out of bed, 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 or activities of daily living which do not require the services of licensed medical personnel.
- I. A Day Care Center is an outpatient psychiatric facility, which is part of, or affiliated with, a Contracting Hospital. It must be licensed according to state and

local laws to provide outpatient care and treatment of Mental and Nervous Disorders or substance abuse under the supervision of psychiatrists.

J. A District is a school district that is a Member, by agreement, of the San Diego County Schools Fringe Benefits Consortium Health Benefit Program.

K. Domestic Partners are “two adults, who have chosen to share one another’s lives in an intimate and committed relationship of mutual caring,” as defined in the Family Code section 297 added by Chapter 588 of the Statutes of 1999. Each Member’s Board policy will dictate whether eligibility is extended to opposite sex partners, same sex partners, or both and the type of documentation The Plan may require as proof of a Domestic Partnership.

L. Durable Medical Equipment (DME), is equipment that is:

1. Designed for repeated use,
2. Mainly and customarily used for medical purposes,
3. Not generally of use to a person in the absence of a disease or injury.

Durable medical equipment includes, but is not limited to, such items as: hospital bed; wheelchair; iron lung; traction apparatus, intermittent positive pressure, breathing machine; orthopedic brace; crutches and other such devices.

M. The Effective Date is the date the Member’s coverage under this Plan Document begins.

N. Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

1. permanently placing the Member’s health or life in jeopardy, or
2. causing other serious medical consequences, or
3. causing serious impairment to bodily functions, or
4. causing serious and permanent dysfunction of any body organ or part.

O. Emergency Care is the initial treatment of an Emergency.

P. Experimental/Investigative procedures are those that are mainly limited to laboratory and/or animal research or those that have progressed to limited use on humans but which are not widely accepted as proven and effective procedures within the organized medical community.

Q. A Family Member is the Member’s enrolled lawful Spouse of the opposite sex, and each enrolled eligible Child. A family member may also be a Domestic

Partner, if the Participating School District includes Domestic Partners in their contract as covered Family Members. Each Participating School District determines the participation of same sex or opposite sex Domestic Partners.

- R. Full-time Student status is considered equivalent to 12 units of credit from an Accredited Educational Institution. Vocational and Trade Schools may entitle a dependent to be considered a Full-time Student if the majority, (e.g. 6 hours daily of an 8 hour day), of the instruction is in a classroom/lecture setting.
- S. Home Health Agencies and Visiting Nurse Associations 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 the Member's home. They must be recognized as home health care providers under Medicare.
- T. A 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 Hospitals (This standard applies to Hospitals within the United States only).
- U. Immediate Family means a Member or any eligible dependents that are covered under this Plan.
- V. Investigative procedures – See “P” in above **DEFINITIONS**.
- W. Medically Necessary services or supplies are those The Plan determines to be:
 - 1. appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
 - 2. provided for the diagnosis or treatment of the medical condition, and,
 - 3. within standards of good medical practice within the organized medical community, and
 - 4. not primarily for the convenience of the Member, the Member's Physician or another provider, and
 - 5. the most appropriate supply or level of service, which can safely be provided. For hospital stays, this means that acute care as an inpatient is necessary due to the type of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a lower level medical setting.
- X. Medicare is the name commonly used to describe health benefits for the aged and disabled provided under Public Law 89-97 as amended.
- Y. Medically Determinable Impairment: a medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical

and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings-not only by the individual's statement of symptoms.

- Z. A Member is the Eligible Employee or Family Member enrolled according to the eligibility stated in the Plan Document.
- AA. Mental or Nervous Disorders are those conditions, including drug or alcohol dependence, which are listed in the International Classification of Diseases as diagnostic codes 290-319. One or more of these conditions may be specifically excluded in this Plan Document.
- BB. Negotiated Rate is the fee Participating Hospitals and Participating physicians agree to accept as payment in full for covered services.
- CC. A Non-Eligible Physician is a Physician who is of a specialty with which The Plan or its agents do not currently enter into Participating Agreements.
- DD. A Non-Participating Physician is a Physician who is eligible to enter into a Participating Agreement with The Plan or its agents but who does not have a Participating Agreement in effect with The Plan or its agents at the time services are rendered.
- EE. A Nurse is a person who is a Nurse Practitioner (N.P.), a Registered Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.), or a Licensed Practical Nurse (L.P.N.).
- FF. Occupational Therapy is the therapeutic use of work, self-care and play activities to increase independent function, enhance development and prevent disability; it may include adaptation of task or environment. This definition may also be used to describe physical therapy performed on the body above the waist.
- GG. An Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient surgical center according to state and local laws and must meet all requirements of an outpatient surgical center providing surgical services.
- HH. A Participating Employer is a public educational agency in California. The employer must be a co-grantor of the SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS CONSORTIUM, and have applied for and been accepted for coverage under this Plan Document.
- II. A Participating Hospital is a Hospital, which has a Participating Agreement in effect with The Plan at the time services are rendered. Participating Hospitals agree to a payment rate, which has been negotiated, with The Plan as payment in full. Participating Hospitals agree to participate in procedures established to review the utilization of inpatient Hospital Services. Hospital Services determined to be unnecessary, according to these utilization review procedures, are not covered by The Plan.

- JJ. A Participating Physician is a Physician who has a Participating Agreement in effect with The Plan or its agents at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for covered services.
- KK. A Physician means:
1. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided and is duly licensed to prescribe and administer drugs and to perform surgery within the scope of his/her license, 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 Plan Document, and when benefits would be payable if the services were provided by a Physician as defined in 1. 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 psychologist
 - f. A chiropractor (D.C.)
 - g. An acupuncturist (but only for acupuncture and for no other services)
 - h. A clinical social worker (C.S.W. or L.C.S.W.)
 - i. A marriage, family and child counselor (M.F.C.C.)
 - j. A physical therapist (P.T. or R.P.T.)
 - k. A speech pathologist
 - l. An audiologist
 - m. An occupational therapist (O.R.T.)
 - n. A physician assistant
- LL. The Plan is the “San Diego and Imperial County Schools Fringe Benefits Consortium Custom Health Benefits Plan and self-funded program.”
- MM. The Plan Document is this document that describes the benefits of the Plan.
- NN. The Plan Document Date is the date this Plan Document comes into effect.
- OO. Psychiatric Health Facility must be fully licensed as a psychiatric facility and accredited by the Joint Commission of Accreditation of Hospitals (JCAHO).
- PP. Pre-existing Condition is an illness, injury or condition that existed within 90 days before the Member’s Effective Date. An illness, injury, or condition is considered to have existed when the Member:
1. sought or received professional advice for that illness, injury, or condition,
 2. received medical care or treatment for that illness, injury, or condition,

3. received medical supplies, drugs or medicines for that illness, injury, or condition.
- QQ. A Related Health Provider is one of the following; licensed according to state and local laws to provide covered medical services:
1. A Certified Registered Nurse Anesthetist
 2. A Registered Nurse
 3. A Licensed Vocational Nurse
 4. A Nurse Practitioner
 5. A Clinical Laboratory
 6. A Skilled Nursing Facility
 7. A Home Health Agency or Visiting Nurse Association
 8. A Licensed Ambulance Company
 9. A licensed retail pharmacy.
 10. A Mid-Wife but only if he/she is also a Licensed Registered Nurse.
- RR. Resourced-Based Relative Value Scale (RBRVS) is the Medicare fee schedule used to determine usual and customary amounts as defined in this document.
- SS. San Diego County Schools Fringe Benefits Consortium Health Benefit Plan is the name of the Plan that provides benefits described by this Plan Document. Reference to that name includes all contracting agencies providing benefits under this Plan.
- TT. Service Area is defined as anywhere inside the State of California.
- UU. A 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 law.
- VV. 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.
- WW. The Spouse is the Member's Spouse under a legally valid marriage between persons of the opposite sex or legally valid contract for Domestic Partners.
- XX. Superintendent is the San Diego County Superintendent of Schools who is the authorized agent of the San Diego County Schools Fringe Benefits Consortium.
- YY. The Plan refers to the San Diego and Imperial County Schools Fringe Benefits Consortium Health Benefits Plan.
- ZZ. Total Disability is defined as the Member's inability to do **any** kind of substantial gainful work because of a physical or mental impairment (or a combination of impairments), which is expected to last at least 12 months or end in death. If, because of a medical condition, a Member cannot do the work that they performed in the past, then age, education, and past work experience must be

considered in determining whether the person can perform other duties. If the evidence shows that the person can perform other duties, even if such duties involve different skills or the compensation is less than that of the previous work, such Member cannot be considered disabled. (The Plan has modeled this provision on the Social Security Administration's definition of "Disability".)

Disability of a dependent child (as defined under Title XVI): a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

- AAA. Treatment means medical and surgical services generally recognized and accepted by the medical profession as the most appropriate covered treatment for the illness or injury of a Member.
- BBB. Usual, Customary and Reasonable is the amount The Plan determines to be the prevailing charge within the general area in which the service was provided. This is based on RBRVS schedules, plus a particular percentage, as defined above under "RBRVS".
- CCC. A Year is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

PART TWO: COMPREHENSIVE BENEFITS

The benefits described below are provided for covered expense incurred for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this Plan Document which may limit benefits or result in benefits not being payable.

A. DETERMINATION OF COVERED EXPENSE

- 1. Covered expense is the expense incurred for a covered service or supply. Expense is deemed incurred on the date the Member receives the service or supply for which the charge is made.
- 2. In no event will covered expense include:
 - a. any charge for services of a Participating Hospital or Participating Physician in excess of the Negotiated Rate, or
 - b. any charge for services for a Non-Participating Physician or Non-Eligible Physician in excess of an allowable charge, or
 - c. any charge for services of a Non-Participating Hospital or Related Health Provider in excess of a reasonable charge.

- d. any charge in excess of the actual billed charges; including but not limited to the Medicare deductible, when billed after a Medicare DRG is paid which is in excess of the actual billed charges of a hospital.

B. DEDUCTIBLE

1. Each Member must meet a deductible amount as outlined in Exhibit “A” for covered expenses incurred during any Calendar Year. When an enrolled family has met the family deductible during any Calendar Year, as outlined in Exhibit “A”, no further deductible is required for the remainder of that Calendar Year.
2. Covered expenses that are incurred during the last quarter of a Calendar Year, and applied toward the deductible for that Year, are also applied toward the deductible for the following Calendar Year.

C. PAYMENT

Payment is provided as follows for covered expenses incurred in excess of the deductible. The Plan will pay the lowest amount the provider accepts as payment in full from any payer, but shall not exceed the Customary and Reasonable Charge. Additionally, all payments are subject to any maximum amounts as outlined throughout this document.

1. First Level Payment

Until The Plan pays the maximum stop/loss level in benefits for covered expense a Member incurs in a Year as shown in Exhibit “B”:

- a. Payment is provided at 90% or 100% of the negotiated rate for a covered expense incurred by that Member for all services provided by a Participating Hospital, Physician or other covered Related Health Provider.
- b. Payment is provided at 70% or 80% of the allowable charge for a covered expense incurred by that Member for all services provided by Non-participating Hospital, Physician or other covered Related Health Provider.
- c. Payment is provided at 90% of the charge when the patient is unable to choose the services of a Participating Provider for the following listed types of providers only. This provision applies only when the services are rendered in California and when care originates at a PPO facility or PPO provider and when the patient has no choice in deciding which provider renders care.
 - Emergency room doctor when care is received in a PPO facility.
 - Inpatient physician hospital visits when inpatient at a PPO facility.
 - Anesthesiologist when the surgeon is a PPO provider.

- Radiologists and laboratories when the patient has no choice.
- d. Payment is provided at 80% when Out-of-Area services are provided to the Member, for Non PPO, ground and air ambulance, for a medical emergency, and for all other Medically Necessary expenses when there is no PPO provider available for that service. For the purposes of this provision “Out-of-Area” means all services incurred outside of the State of California.

2. Second Level Payment

After the Plan pays the maximum stop/loss level in benefits for covered expenses a Member incurs in a Year as shown in Exhibit “B,” payment is provided for 100% of the covered expense incurred by that Member for the remainder of the Calendar Year for all covered services. Not included in this provision are those benefits that are “carved out” to a third party entity such as prescription drugs, mental and nervous benefits etc.

D. MAXIMUM BENEFITS

1. Lifetime Maximum

The lifetime maximum benefit per individual Member is listed in Exhibit “D”.

2. Mental or Nervous Disorders

Benefits paid under Mental or Nervous Disorders and Substance Abuse for inpatient Hospital care and outpatient visits to a Day Care Center are limited to a maximum payment for covered expense incurred during each Member’s lifetime as shown in Exhibit “D” and Exhibit “G”.

3. Chiropractic Benefit Maximum

Benefits paid under chiropractic care/treatment are outlined in Exhibit "C".

4. Acupuncture Benefit Maximum

Benefits paid under acupuncture treatment are outlined in Exhibit "C".

Any additional limits on the number of visits or days-covered are stated under the specific benefit.

E. PRE-EXISTING CONDITIONS

Benefits in excess of the amount shown in Exhibit “E” will not be provided for any services received on, or within twelve months after, the Member’s Effective Date if they are related to a Pre-existing Condition. The pre-existing condition

clause applies to any newly hired or newly eligible Member/Dependent or to any Member/Dependent who has had a break in coverage. This paragraph does not apply to a Member who was covered under another District sponsored plan, (through the same School District), and replaced by this Agreement within 30 days of that plan's termination. It also does not apply to Pregnancies, Adopted Children who are being adopted and become covered within 30 days of birth, adoption or placement or to a Child born to a Member, and enrolled within the allotted time period, who is already enrolled under this Agreement.

F. COVERED EXPENSE

1. Hospital

a. Covered Services

- (1) Inpatient services and supplies provided by a Hospital, except private room charges over the prevailing two-bed room rate of the Hospital. Emergency room use requires a co-payment as outlined in Exhibit "F" regardless of whether the Member is admitted to the Hospital or not.
- (2) Outpatient services and supplies provided by a Hospital, including those in connection with surgery performed at a Licensed Outpatient Surgical Center.

b. Conditions of Service

- (1) Services must be those that are regularly provided and billed by a Hospital.
- (2) Benefits are provided only for the minimum number of days required to treat the Member's illness, injury or condition.

2. Psychiatric Health Facility – Must be fully licensed as a psychiatric facility and accredited by the Joint Commission of Accreditation of Hospitals (JCAHO).

3. Skilled Nursing Facility

a. Covered Services

Inpatient services and supplies provided by a Skilled Nursing Facility, except private room charges over the prevailing two-bed room rate of the Skilled Nursing Facility.

b. Conditions of Service

- (1) The Member must be referred to the Skilled Nursing Facility by a Physician.
- (2) Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- (3) The services must be consistent with the illness, injury, degree of disability and medical necessity of the Member. Benefits are provided only for the number of days required to treat the Member's illness or injury.

- (4) The Member must remain under the active medical supervision of a Physician treating the illness or injury for which the Member is confined in the Skilled Nursing Facility.
 - (5) Admission to a Skilled Nursing Facility for non-skilled or custodial care is excluded.
4. Home Health Care
 - a. Covered Services
 - (1) Services of a registered nurse.
 - (2) Services of a licensed Therapist for physical therapy covered occupational therapy or covered speech therapy.
 - (3) Services of a medical social service worker.
 - (4) Services of a Licensed Vocational Nurse who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency or Visiting Nurse Association as professional coordinator. These services are only covered if the Member is also receiving the services listed in (1) or (2) above.
 - (5) Necessary covered medical supplies provided by the Home Health Agency or Visiting Nurse Association.
 - (6) Custodial care is excluded.
 - b. Conditions of Service
 - (1) The Member must be confined at home under the active medical supervision of the Physician ordering home health care and treating the illness or injury for which that care is needed.
 - (2) Services must be provided and billed by the Home Health Agency or Visiting Nurse Association.
 - (3) Services must be consistent with the illness, injury, degree of disability and medical needs of the Member. Benefits are provided only for the number of visits required to treat the Member's illness or injury, up to a maximum of 100 visits per calendar year. (A visit is a shift of 8 hours or less).
5. Professional Services
 - a. Services of a Physician or Physician Assistant as defined in another portion of this Plan Document.
 - b. Services of an Anesthetist
 - c. Services of a Registered Nurse
 - d. Services of a midwife who is also a Registered Nurse acting within the scope of his/her license.

6. Additional Services and Supplies

- a. The following ambulance services:
- (1) Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and from a Hospital for a medical emergency, including ambulance services utilized by the “911” emergency response system.
 - (2) Base charge, mileage and non-reusable supplies of an air ambulance from the area where the Member is first disabled to transport a Member to the **nearest** Hospital for a **medical emergency**.
 - (3) Monitoring, electrocardiograms (EKG’s or ECG’s), cardiac defibrillation, cardiopulmonary resuscitation (CPR), administration of oxygen and intravenous (IV) solutions and other necessary services in connection with ambulance service. An appropriately licensed person must render the services.
- b. Outpatient diagnostic radiology and laboratory services for treatment of an illness or injury. Multiple non-emergency laboratory tests will be paid as Automated Multichannel Tests.
- c. Radiation therapy, chemotherapy, hemodialysis and other such FDA approved, Physician ordered, non Investigational or Experimental treatment appropriate for the diagnosed illness or injury.
- d. Surgical implants, except devices used in non covered cosmetic procedures.
- e. Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or fitting of a covered orthotic or prosthetic device when services are billed as part of the charge for the artificial limbs or eyes. Initial device only. This does not include repair or replacement of existing prosthetic devices.
- f. The first pair of contact lenses and the first pair of eyeglasses when required as a result of Medically Necessary eye surgery.
- g. Rental or purchase, (depending on the expected duration of treatment), of dialysis equipment and supplies. Rental or purchase of other durable medical equipment and supplies which are:
- (1) Ordered by a Physician, and
 - (2) of no further use when medical need ends, and
 - (3) usable only by the patient, and
 - (4) not primarily for the Member’s comfort or hygiene, and
 - (5) not for environmental control, and
 - (6) not for exercise, and
 - (7) manufactured specifically for medical use.

Rental charges that exceed the reasonable or negotiated purchase price of the equipment are not covered. The Plan determines whether the item meets the above conditions. If more than one choice exists, benefits will be provided for the least costly item determined to be medically adequate. Rental charges may not be billed in advance of delivery.

- h. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
- i. Mastectomy including breast reconstruction after mastectomy and complications from mastectomy. Surgery to perform a Medically Necessary mastectomy and lymph node dissection is covered, including prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Member due to the mastectomy or lumpectomy. The length of a hospital stay is determined by the attending physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries and initial prosthetic device for the diseased breast on which the mastectomy was performed and for a healthy breast if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphadema, is covered. Additionally, screening procedures, as recommended by the Member's physician is covered.
- j. Papanicolaou test (Pap Smear) for all females as recommended by the Member's Physician.
- k. Hospice Care Services for up to 60 days in a Calendar Year for these services: (In home hospice services are also subject to the home health care benefit maximums)
 - (1) Room and Board charged by the Hospice
 - (2) other covered Services and Supplies
 - (3) part-time nursing care by or supervised by a registered graduate nurse (R.N.) (L.V.N.) or (L.P.N)
 - (4) Home Health Care Services as described under the Home Health Care benefit; limited to one hundred visits per Calendar Year
 - (5) counseling for the Member and the Member's eligible dependents as provided through the outpatient mental and nervous provisions
 - (6) Custodial care is excluded.

Services for the patient must be given in an inpatient Hospice facility or the patient's home. An attending Physician must certify that the patient is terminally ill with a life expectancy of 6 months or less.

- l. Outpatient surgical supplies used in conjunction with eligible outpatient surgery. Such supplies are subject to the Usual, Customary and Reasonable amounts as defined in this document.

7. Dental Care

a. Admissions for Dental Care

(1) Covered Services

Listed inpatient or outpatient Hospital or surgical services, subject to the conditions of service stated above, when a Hospital stay for dental treatment is required due to an unrelated medical condition of the Member, and has been ordered by a Physician (M.D.) and a Dentist (D.D.S.) or (D.M.D.).

(2) Conditions of Service

- (a) The Plan makes 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 the Member's medical condition.
- (b) Hospital stays for the purpose of administering general anesthesia are not a covered expense.

b. Dental Injury

Services of a Physician (M.D.) or Dentist (D.D.S.) treating an Accidental Injury to natural teeth which occurs while the Member is covered under this Plan Document. **All services must be received during the six months following the date of injury.** Damage to natural teeth due to chewing or biting is not considered an Accidental Injury under the terms of this provision.

8. Pregnancy and Maternity Care

- a. All Comprehensive Benefits when provided for pregnancy and maternity care, including the California Department of Health Services expanded Alpha Feta Protein (AFP) Testing Program.
- b. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- c. Comprehensive Hospital benefits for routine nursery care of a newborn Child, if the Child's natural mother is a Member or the enrolled Spouse/Domestic Partner is a Member, and the newborn Child is

- enrolled as a dependent within 31 days of birth and any additional premium, if any, are paid.
- d. Termination of pregnancy.

9. Family Planning

Limited to one consultation per Member while eligible under the plan.

10. Organ and Tissue Transplants

Subject to the Utilization Management provisions of this Plan Document outlined in PART SEVEN, all services previously described under Covered Expense are provided under the same terms and conditions for services in connection with a Non-Investigative organ or tissue transplant, such as skin, cornea, kidney transplants, that are commonly accepted medical practice in the United States. The Plan provides coverage for:

- a. An enrolled Member who receives the organ or tissue, and
- b. an enrolled Member who donates the organ or tissue, and
- c. the donor providing the organ or tissue whom is not an enrolled Member, if the recipient is an enrolled Member. Benefits are reduced by any amounts paid or payable by the donor's own health plan coverage.

Exceptions: Benefits for human heart transplants and human liver transplants will be provided only if benefits are authorized in advance. Such authorization will be provided only if both of the following criteria are met:

1. Services are Medically Necessary, and
2. The Physicians on the surgical team and the facility in which the transplant is to take place are approved for human transplants by The Plan.

Benefits for authorized services are subject to all other conditions, limitations, exclusions and provisions of this Plan Document. No benefits are provided for transplant procedures that are investigational.

The Member or the Member's Physician must call The Plan's review agency for authorization prior to scheduling a Hospital admission for human heart or human liver transplant.

11. Mental or Nervous Disorders and Substance Abuse

a. Covered Services

- (1) Inpatient Hospital services stated above limited to 30 days per year and the lifetime limits as stated in Exhibit D and Exhibit G, and
- (2) visits of a Physician during a covered inpatient stay, limited to one visit a day, subject to all maximums, and
- (3) certain outpatient diagnostic and medication monitoring.

b. Conditions of Service

- (1) Services must be for treatment of substance abuse (such as drug/alcohol dependence) or a Mental or Nervous Disorder (such as schizophrenia, schizo affective disorder, bipolar disorder, delusional depressions, pervasive development disorder, affective mood disorder, or autism) and conditions which can be improved by standard medical practice.
- (2) The Member must be under the direct care of a Physician for the condition being treated.
- (3) Inpatient services must be those which are regularly provided and billed by a Hospital.
- (4) Inpatient benefits are provided only for the number of days required to treat the Member's illness, injury or condition.

The above benefits apply to those Members that do not have the mental or nervous disorders and substance abuse benefits provided through an insured contract as listed in Exhibit "G".

12. Preventive Care

- a. The following service when rendered to a Member who is a dependent Child to the age of 19.
 - (1) Non Medically Necessary, or routine Immunizations which are considered standard medical practice.
 - (2) Well baby care, as outlined in Exhibit "H". All deductibles and co-payments apply.
- b. Routine physical exams as outlined in Exhibit "H". All deductibles and co-payments apply.
- c. Adult immunizations as outlined in Exhibit "I".

PART THREE: PRESCRIPTION DRUG BENEFITS

Benefits described in this Part are provided for expense incurred for prescription drugs only if benefits have not been provided elsewhere in this Plan Document. Expense is incurred on the date the Member receives the drug for which the charge is made.

A. PAYMENT

1. When the Member presents his or her drug identification card (an identification card issued by The Plan or its agents) at a participating pharmacy (a pharmacy which has signed an agreement with The Plan), the Member pays a Co-Pay or Coinsurance, and in quantities as outlined in

Exhibit “J” for each prescription and each refill. A list of participating pharmacies is available upon request.

2. When the Member does not present his or her drug identification card, or goes to a non-participating pharmacy, payment is provided to the Member for the reasonable charge for covered expense incurred, less a deductible as outlined in Exhibit “J” for which the Member is responsible. The reasonable charge is determined by The Plan. This benefit is payable only if the Member files a properly completed claim form within 90 days of the date of purchase, but never later than 365 days of the date of purchase.

B. COVERED EXPENSE

Drugs and medications which the law restricts for sale by prescription in the United States. Insulin, needles and syringes for use with the insulin.

C. CONDITIONS OF SERVICE

The drug or medication must satisfy all of the following requirements:

- a. be prescribed in writing by a Physician and be dispensed within one year of being prescribed
- b. be a prescription for properly prescribed Food and Drug Administration (FDA) approved drugs that are Medically Necessary
- c. be for the direct care and treatment of the Member’s illness, injury or condition
- d. be purchased from a licensed retail pharmacy not to be used while the Member is an inpatient in any facility, unless it is not usually supplied by or used in that facility

D. PRESCRIPTION DRUG - EXCLUSIONS AND LIMITATIONS

Prescription drug benefits are not provided for or in connection with (but not limited to) the following:

1. Medicines not requiring a prescription, except insulin.
2. Contraceptive medications, materials or devices, except as outlined in Exhibit J.
3. Vitamins regardless of Medical Necessity. (Unless the vitamin is the only known treatment for the Illness or Injury)
4. Tretinoin, all forms (e.g., Retin-A, Renova) or any other acne medication for Members over 25 years of age, unless a physician certifies that the drug is for a Medically Necessary reason.
5. Charges for administration of any drug.
6. Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use. (Except two pairs of medical support hose per year for a diagnosed peripheral vascular disorder).
7. Prescriptions that a Member is entitled to receive without charge from any Workers’ Compensation laws.

8. Medication taken or administered while in a hospital, extended care facility, nursing home or similar institution (these charges are paid by the health plan).
9. Any prescription filled in excess of the number specified by the Physician, or any refill dispensed after one year from the original fill date.
10. Dietary supplements, health aids or drugs for the purpose of birth control unless otherwise specified.
11. Anorectic (drugs used for weight control).
12. Nicorette (or any other drug for which the intended use is to deter smoking).
13. Infertility medications.
14. Yocon (Yohimbine).
15. Any prescription drug for treatment of a benefit excluded by the health plan.
16. Any drug that is limited by Federal Law to "Investigational Use" or experimental drugs. Any drug or medication not generally considered acceptable as a form of treatment for a given diagnosis.
17. Any drug which the Food and Drug Administration has not approved for general use.
18. Any drugs dispensed by a physician, dentist or podiatrist.
19. Rogaine, Minoxidil or any other product to promote hair growth regardless of the reason for the hair loss.
20. Immunization agents, biological sera, blood or plasma
21. Any drug for treatment of a benefit excluded in the health plan

PART FOUR: BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For all Medicare-eligible Members, The Plan provides the benefits of this Plan Document as outlined in Exhibit "K".

PART FIVE: EXTENSION OF BENEFITS

A. COBRA

Continuation of coverage shall be available in accordance with COBRA requirements for an eligible Member, spouse/domestic partner or dependent if a qualifying event occurs that would cause the eligible Member, spouse/domestic partner or dependent to lose coverage under this Plan. A qualified beneficiary also includes any child who is born to or adopted by, a covered employee within the period of continued coverage, and who has been enrolled in the Plan.

Under COBRA, an individual's right to continuation coverage terminates if they become covered by another employer's group health plan that does not limit or exclude coverage for preexisting conditions. If an individual becomes covered by another group health plan and that plan contains a preexisting condition limitation that affects such individual, COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to such

individual by reason of HIPAA's restriction on preexisting condition clauses, the District may terminate COBRA coverage.

When a qualifying event occurs, a COBRA election form along with the premium information will be sent, by the District, to the Member or dependent. Election for continuation of coverage must be made within 60 days from the qualifying event or the date of notification, whichever is later. The premium must be paid within 45 days of the date of the COBRA election. Members and dependents are responsible for notifying the School District within 60 days of a qualifying event affecting dependents.

A qualifying event is:

1. The death of the covered Member.
2. The termination (other than by reason of such Member's gross misconduct), or reduction of hours, of the covered Member's employment.
3. The divorce or legal separation of the covered Member from the Member's spouse/domestic partner.
4. The covered Member becoming entitled to benefits under Title XVII of the Social Security Act (Medicare).
5. A dependent child ceases to be a dependent child under the eligibility requirements of this Plan.

If elected, the continued coverage will end on the earliest of the following:

1. 18 months after the date of termination of the employee's employment (other than for gross misconduct) or reduction of hours worked which renders the employee ineligible for coverage. If a Member is determined to have been disabled for Social Security purposes at the time of the qualifying event or any time during the first 60 days of COBRA coverage, and gives The Plan notice within sixty (60) days of receipt of disability determination from Social Security and before the end of the 18-month COBRA continuation period, the continuation coverage may extend to twenty-nine (29) months. Also, a second qualifying event, occurring during the initial 18 months, could extend coverage up to a maximum of 36 months.
2. 36 months after the date of any other qualifying event.
3. The date on which the District ceases to provide any group's health plan to any employee.
4. The date on which coverage ceases under the plan by reason of a failure to make timely payment required under the Plan with respect to the qualified Member, Spouse/Domestic Partner or Dependent.
5. The date on which the qualified Member, Spouse/Domestic Partner or Dependent first becomes covered under another group health plan that does not include a preexisting conditions clause that is applicable.
6. The qualified Member, Spouse/Domestic Partner or Dependent becomes entitled under Medicare.

If a Member does not choose COBRA continuation coverage The Plan coverage will terminate in accordance with eligibility requirements outlined in another section of this Plan Document.

B. TOTALLY DISABLED

A Member confined as an inpatient in a Hospital or Skilled Nursing Facility, who is under the treatment of a Physician when coverage under this Plan would end, but before the COBRA continuation coverage begins, is considered to be totally disabled and may continue to be entitled to benefits for treating the totally disabling illness or injury as long as the inpatient stay is Medically Necessary. No benefits shall be provided for services treating any other illness, injury or conditions. Benefits are provided until one of the following occurs:

1. The Member is no longer an inpatient in a Hospital or Skilled Nursing Facility; or
2. The maximum benefits of the Plan are paid; or
3. The Member becomes covered under another health plan that provides coverage without limitation for the disabling illness, injury, or condition; or
4. A period of twelve (12) consecutive months has passed since the date coverage ended, or would have ended, if an extension of benefits had not been provided under this section of the Plan Document.

NOTE: Extension of Benefits shall not be provided if the Member is required to pay the whole or any part of the premium charges required under the terms of this Plan Document and such Member ceases to pay such premium charges while this Document is in effect. COBRA coverage will not be extended beyond the periods stated in part 5.A. above even if a Member is Totally Disabled.

C. EDUCATION CODE SECTION 7000/AB528

Under AB528, passed in 1985, school districts, community colleges and county superintendents which provide health and welfare benefits or dental care benefits for certificated employees are required to permit former certificated employees, who were enrolled in these plans as active employees and retire under any public retirement system, the opportunity for continued coverage under these plans. If the retiree elects to continue coverage they may include their spouse/domestic partner but not their children. Also, the surviving spouse/domestic partner of one of these retirees or of an active certificated employee, who is contributing to STRS and is a member of STRS, may continue coverage. Election for continued coverage must be made within 31 days of termination of active coverage, otherwise coverage is forfeited. Re-enrollment is not available if coverage is dropped.

PART SIX: CHRISTIAN SCIENCE BENEFITS

A. NURSE

Benefits will be provided for personal care and attendance of a Christian Science Nurse authorized by the Mother Church, and who are not Members of the Member's family.

1. Maximum per hour \$4.00
2. Maximum visit per day One
3. Maximum hours per visit 5
4. Maximum visits per calendar year 70

B. PRACTITIONER

Benefits will be provided for personal care and attendance of a Christian Science Practitioner currently listed in the Christian Science Journal.

1. Maximum per visit \$10.00
2. Maximum visit per day One
3. Maximum visits per calendar year 70

C. SANATORIUM

Benefits will be provided for room and board in a Christian Science Sanatorium of the Mother Church, and other nursing homes that may, from time to time, be approved by the Christian Science Nursing Home Committee of the Mother Church, up to 70 days per calendar year.

PART SEVEN: UTILIZATION MANAGEMENT

Benefits are provided only for Medically Necessary services. Utilization management provides the Member with valuable information about the medical necessity of services, so that unexpected out-of-pocket costs can be avoided. When the utilization management programs are properly used, the Member will know in advance whether the services are Medically Necessary and therefore eligible for benefits.

Utilization management programs are designed to work together. The utilization review program applies to Hospital admissions. The Personal Case Management Program helps Members coordinate and manage long-term intensive medical care.

NOTE: Utilization management requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for the Members.

A. UTILIZATION REVIEW PROGRAM

The Utilization review program evaluates the medical necessity of care and the setting in which care is provided. Members and Physicians are advised when services can be safely provided in an ambulatory outpatient setting or when an inpatient stay is recommended. Services that are Medically Necessary are certified for an appropriate period and monitored so those Members know when it is no longer Medically Necessary to continue those services.

1. Utilization Review Requirements of This Plan Document

This plan requires utilization reviews when the following services are received:

All inpatient Hospital

There are three stages of utilization review.

- (1) Prospective review determines the medical necessity of scheduled (non-Emergency) Hospital admissions.
- (2) Concurrent review determines whether services continue to be Medically Necessary. The two types of concurrent review are service review and continued service review. Service review evaluates the Medical Necessity of services when prospective review is not required or has not been performed as required. Continued service review is performed after prospective review to determine the medical necessity of ongoing treatment.
- (3) Retrospective review is performed when the review agency was not notified and therefore has been unable to perform the appropriate prospective or concurrent review.

2. How Benefits are Affected by Utilization Reviews

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

- a. The appropriate utilization reviews must be performed. When prospective review is not performed as required for a Hospital admission, the Member shall have an additional \$300 deductible per admission.
- b. The services must be Medically Necessary as defined.
 - (1) Inpatient Hospital benefits will be provided only when an inpatient stay is Medically Necessary.
 - (2) If the Member proceeds with inpatient services that have been determined to be not Medically Necessary at any stage of the utilization review process, benefits will not be provided for those services.

No benefits are payable, however, unless the Member's coverage is in force at the time services are rendered, and the payment of benefits is subject to all terms and requirements of this Plan Document.

Services that are not reviewed through the applicable utilization reviews will be reviewed 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, benefits will not be paid for those services, and remaining benefits are subject to any previously noted reductions that apply when the required reviews are not obtained. This review will only be conducted upon receipt of the complete medical records of the Members.

3. How to Obtain Utilization Reviews

a. Prospective Reviews

Benefit penalties will result for failure to obtain prospective review for all scheduled services that are subject to the utilization review requirements of this plan, the Member or the Member's Physician must initiate the prospective review at least three working days prior to when the Member is scheduled to receive services or within 48 hours after an Emergency admission.

The Member must tell his or her Physician that this plan requires prospective review. Preferred Provider Physicians will initiate the review on the Member's behalf. A Non-Preferred Provider Physician may initiate the review for the Member, or the Member may call the review agency directly. The review agency's telephone number is printed on the Member's identification card.

If the Member does not receive the certified service within 20 days of the certification, or if the nature of the service changes, a new prospective review must be obtained by following the procedures described above.

It is always the Member's responsibility to confirm that the review has been performed.

If the review agency determines that the proposed services are Medically Necessary, the review agency will certify those services for the period of time that is medically appropriate. The Member, the Member's Physician and the provider of services will receive notice indicating that the service has been approved.

If the review agency determines that the proposed services are not Medically Necessary, the Member's Physician will be notified immediately. Written notice then will be sent to the Member, the Member's Physician and the Provider of the services.

If prospective review was not required or performed as required or if the services the Member receives exceed the originally certified period, the services are subject to concurrent review and retrospective review described below.

b. Concurrent Reviews

If prospective review was not required or performed as required, the Member, the Member's Physician or the provider of service must contact the review agency for service review. For Emergency Hospital admissions, the review agency must be notified within two working days of the admission.

When they have been informed of the Member's need for utilization reviews, Preferred Providers will initiate the review on the Member's behalf. The Member may ask a Non-Preferred Provider to call the review agency, or the Member may call the review agency directly. The review agency's telephone number is printed on the Member's identification card.

It is always the Member's responsibility to confirm that the review has been performed.

If the review agency determines that the service is Medically Necessary, the review agency will certify the service for the period of time that usually is medically appropriate for the type of treatment or procedure required. Also, the review agency will determine if Hospital services require inpatient care or if they can safely be rendered in an outpatient setting.

If the review agency determines that the service is not Medically Necessary, the Member and the Member's Physician will receive written notice that certification will expire as specified in the notice.

Continued service review will be automatically initiated when prospective review or service review has been performed. Continued service review includes an evaluation of whether it is Medically Necessary for the Member to receive services for a longer period of time than originally was certified.

If it is Medically Necessary for services to be continued longer than originally certified, an extension also will be certified. If the continued service review determines that continued treatment is not Medically Necessary, the Member and the Member's Physician will receive notice that certification will expire as stated in the notice.

c. Retrospective reviews

Retrospective review is performed when the review agency has not been notified of the services the Member received and therefore has been unable to perform the appropriate review prior to the Member's discharge from the Hospital or completion of outpatient treatment.

Hospital admissions that are retrospectively reviewed and determined to have not been Medically Necessary will be retrospectively denied certification.

B. PERSONAL CASE MANAGEMENT PROGRAM

The Personal Case Management Program allows Members to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care. The Plan may recommend an alternative plan of treatment that may include services not specifically covered under the Plan Document. The Plan provides these services at its sole option. The Member does not have a right to request personal case management.

1. How the Personal Case Management Program Works

- a. Members may be identified for personal case management through the procedures described under UTILIZATION MANAGEMENT by the attending Physician, Hospital staff, utilization reports, other pertinent reports. Additionally, the Member or the Member's family may call The Plan to request this service. The plan or an agent of the Plan will determine whether or not the Member is a candidate for Utilization management.
- b. The Plan will determine when personal case management will be offered. Benefits for personal case management will be considered only when all of the following criteria are met:
 - (1) The Member requires extensive long-term treatment, and
 - (2) The Plan anticipates that utilizing such treatment, services or supplies covered under this Plan Document will result in considerable cost, and
 - (3) A cost-benefit analysis by The Plan determines that the benefits payable under this Plan Document for the alternative plan of treatment can be provided at a lower overall cost than the benefits the Member would otherwise receive under this Plan Document, and
 - (4) The Member (or the Member's legal guardian) and the Member's Physician agree, in a letter of agreement, with The Plan's recommended substitution of benefits and with the specific terms and conditions under which the alternative benefits are to be provided.
- c. If The Plan determines that the Member's needs could be met more efficiently, an alternate treatment plan may be recommended. This may include providing benefits not otherwise specifically covered under this plan. The Plan case manager will review the medical records and discuss the course of treatment with the attending Physician, the Member and the Member's family.

d. The Plan makes treatment recommendations only; any decisions regarding the Member's treatment belong to the Member and the Member's Physician although the ultimate treatment may not be a covered expense under the terms of this Plan. The Plan will in no way prejudice or compromise the Member's freedom to make such decisions.

2. How Benefits are Affected by the Personal Case Management Program

- a. Any alternative benefits paid are accumulated toward any lifetime maximums.
- b. Benefits are provided for an alternative treatment plan on a case-by-case only. The Plan has absolute discretion in deciding whether or not to substitute benefits for any Member, which alternative benefits may be offered and the terms of the offer.
- c. The Plan's substitution of benefits in a particular case in no way commits The Plan to do so in another case or for another Member.
- d. The Personal Case Management Program does not prevent The Plan from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other Member.

Note: The Plan reserves the right to use services of one or more third parties in the performance of services.

C. DISAGREEMENTS WITH UTILIZATION MANAGEMENT DETERMINATIONS

- 1. If the Member or the Member's Physician disagrees with The Plan's utilization management determination or questions how it was reached, reconsideration may be requested. The Member, the Member's representative or the Member's Physician may make the request. Requests for reconsideration must be directed to the review agency that made the review determination. Written requests must include medical information that supports the medical necessity of the services.
- 2. If the Member does not receive a response to the request for reconsideration within 60 days it is automatically deemed denied.
- 3. If the reconsidered decision is not satisfactory, a request for an appeal of the reconsidered decision may be submitted in writing to The Plan. The Member, the Member's representative or the Member's Physician may make the appeal request.
- 4. In the event that the appeal decision still is unsatisfactory, the remedy is BINDING ARBITRATION or small claims action as stated elsewhere in this Plan Document.

PART EIGHT: EXCLUSIONS AND LIMITATIONS

The following is not meant to be an all-inclusive list of exclusions and limitations.

Benefits of this Plan Document are not provided for or in connection with the following:

- A. Services or supplies that are not Medically Necessary as defined.
- B. Experimental or Investigative procedures, including any type of therapy not widely recognized as of value by the medical community and its societies, are not covered; all other charges, including but not limited to: office visits, laboratory procedures, or other related services incurred in conjunction with non-covered services, treatment or therapy are also excluded.
- C. Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends, except as specifically stated under Extension of Benefits.
- D. Any charge of a Participating Hospital or Participating Physician in excess of the Negotiated Rate.
- E. Any charge of a Non-Participating Physician or Non-Eligible Physician in excess of the allowable charge.
- F. Any charge of a Non-Participating Hospital or Related Health Provider in excess of allowable charges.
- G. Services not specifically listed in this Plan Document as covered services.
- H. Services for which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance 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, and
 - 2. At least ten percent of its yearly budget must be spent on research not directly related to patient care, and
 - 3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and
 - 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.
- I. 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 the Member does not claim those benefits.
- J. Conditions caused by an act of war, terrorism, or invasion. Conditions caused by atomic, biological, or chemical release, whether or not such release is as the result of declared or undeclared war.

- K. Any services or supplies provided by a local, state or federal government agency, regardless of whether application is made, unless the covered person is legally required to pay for such service in the absence of insurance or is required by law or federal law mandates payments by group health plans.
- L. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage or is part of the Immediate Family.
- M. Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial care, domiciliary care, or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility, regardless of how denominated. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Comprehensive Benefits.
- N. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests, or other services, which could have been performed safely on an outpatient basis.
- O. Hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood. Mental or nervous disorders and/or substance abuse, except as specifically stated elsewhere in this Plan Document.
- P. Braces, other orthodontic appliances or orthodontic services, including surgery to correct malocclusion.
- Q. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated for Dental Care under Comprehensive Benefits. Treatment of dental abscess, granuloma, gingival tissues or dental examinations. Cosmetic dental surgery or other services for beautification or cosmetic purposes.
- R. Hearing aids and/or routine hearing tests.
- S. Optometric services, eye exercises including orthoptics, vision therapy, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Comprehensive Benefits. Radial keratotomy, Lasix or any other procedure to treat a refractive error of the eye such as nearsightedness (myopia) and/or astigmatism. Any procedure to treat farsightedness.
- T. Outpatient occupational therapy, except when rehabilitation is concerned with restoration of function and prevention of disability following disease, injury or loss of body parts or except when provided by a Home Health Agency or Visiting Nurse Association as specifically stated in Home Health Care under Comprehensive Benefits.
- U. Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.

- V. Cosmetic or plastic surgery or other services for beautification or comfort, including but not limited to: Surgical excision or reformation of any sagging skin of or on any part of the body including but not limited to the eyelids, face, neck, abdomen, arms, legs or buttocks; any services performed in connection with the enlargement, reduction, or change in appearance of a portion of the body including but not limited to the breasts, lips, jaw, chin, nose, ears, or genitals; hair transplantation; chemical face peels or abrasion of the skin; or electrolysis epilation. This exclusion shall not be applicable when the surgery; or other services are performed to correct or repair the physical functioning of a body part as a result of a medical complication resulting from surgery or an accidental injury occurring while the Member is covered under this Plan Document and for which the Member submits to The Plan documented evidence showing medical treatment of such accident at the time of injury.

Cosmetic or reconstructive service exclusions determined in accordance with the standard care as practiced by physicians specializing in reconstructive surgery include, but are not limited to:

1. Proposed surgery when there is another more appropriate surgical procedure that has been offered to the Member.
2. Services that offer only a minimal improvement in the Member's appearance.

When services are determined to be cosmetic, all services to be provided as part of the cosmetic treatment plan are also excluded, including but not limited to: hospital, physician, anesthesiologist, lab, x-ray, medical supplies or medications (injectable, intravenous, oral, or by any other delivery system.).

- W. Services primarily for weight control or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:
1. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity, and
 2. It has been documented that non-surgical treatments of the life threatening obesity have failed.
- X. Procedures or treatments to change characteristics of the body to those of the opposite sex, and any other treatment or studies related to sex transformation.
- Y. Sterilization, sterilization reversal, artificial insemination and in vitro-fertilization or any other medical, surgical, or pharmaceutical intervention intended to bring about pregnancy.
- Z. Birth control devices or medication except as outlined in Exhibit "J".
- AA. Orthopedic shoes (except when joined to braces) or shoe inserts, orthotics, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Any routine non-surgical treatment of feet; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except for cutting operations. Also, treatment of corns, calluses or toenails, except the removal of nail roots and necessary services in the treatment of metabolic peripheral-vascular disease.

- BB. Routine physical exams or screening tests which do not directly treat an actual illness, disease or injury, including those required by employment or government authority, except as specifically stated elsewhere in this document.
- CC. Services or supplies for the treatment of an illness, disease or injury if:
1. Coverage under this Plan Document becomes effective within 30 days after the termination of a prior carrier's plan, and
 2. The Member was Totally Disabled on the date that the prior carrier's plan terminated, and
 3. The Member is entitled to an extension of benefits under Section 1399.62 of the California Health and Safety Code, Section 10128.2 of the California Insurance Code or to any similar extension of coverage for the totally disabling condition.
- DD. Benefits provided by another health benefit plan will have benefits applied in accordance with provisions of the Coordination of Benefits section of this Plan Document.
- EE. Expenses for screening and testing of potential organ or tissue donor.
- FF. Educational services.
- GG. Nutritional counseling or food supplements regardless of the illness or injury or necessity of such services.
- HH. Telephone consultations.
- II. Any injury or illness, directly or indirectly, caused by suicide or intentionally self-indicated injuries or illnesses whether sane or insane; or any injury sustained in the act of committing a felony.
- JJ. Custodial care is excluded, regardless of who prescribes or renders such care.
- KK. Any amount that was discounted by another carrier's PPO contract. Any amount in excess of the lowest amount the provider accepts as payment in full.
- LL. Services not prescribed by a licensed Physician as defined elsewhere in this Plan Document.
- MM. Laetrile is excluded.
- NN. Digestive aids, vitamin and mineral supplements, taken orally or injected, regardless of whether they are prescribed by a Physician except as stated elsewhere in this document.
- OO. Charges for unkept appointments, completion of claim forms or providing supplementary information, or interviews in which the patient is not seen.
- PP. Post surgical treatment during the postoperative follow-up period when such follow-up is normally considered part of the surgical treatment.

- QQ. Duplicate prosthetic devices or durable medical equipment or repair or replacement of damaged, lost or stolen prosthetic devices or durable medical equipment.
- RR. Travel expenses, except as otherwise specified.
- SS. Services payable by reason of any false statement.
- TT. Standby physicians except as may be considered Medically Necessary when a Cesarean Section is performed because of increased risks with infants delivered by Cesarean Section and greater chance of immediate difficulty at birth.
- UU. Marriage, family, career, pastoral or financial counseling.
- VV. Residents or interns of a hospital.
- WW. Drugs dispensed by a physician, dentist or podiatrist.
- XX. Charges for photographs, photocopying and/or videos.
- YY. Exercise programs or exercise equipment regardless of Medical Necessity.
- ZZ. Any maintenance or comfort items or equipment regardless of Medical Necessity (i.e. spa, hot tubs, pools, steam rooms, therapeutic mattresses, pillows, any type of home modifications, etc.)

PART NINE: COORDINATION OF BENEFITS

All of the benefits provided by this Plan Document are subject to the following provisions and limitations regardless of any other provisions of this Plan Document.

A. DEFINITIONS

1. Other Plan means any of the following plans that provide full or partial benefits or services for hospital, surgical, medical, vision or dental care treatment.
 - a. group, blanket or franchise insurance coverage;
 - b. any group coverage under labor-management trust plans, union welfare plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
 - c. Any governmental program, or that provided by any state or federal statute.

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

2. This Plan Document means the portion of the Plan Document providing benefits that are subject to this provision.
3. Allowable Expenses means any necessary, Usual, Customary and Reasonable item of covered expense of This Plan which is at least partially covered under at least one of the Other Plans covering the person for whom claim is made.
4. Claim Determination Period means a year.
5. Covered Individual means a person covered for hospitalization, surgical, medical, vision or dental services and benefits under both this Plan Document and the Other Plan.

B. ORDER OF BENEFITS DETERMINATION

1. This provision applies in determining the benefits of a Covered Individual under this Plan Document for any expenses incurred by that Covered Individual during any Claim Determination period, the sum of:
 - a. the benefits that would be provided under this Plan Document without this provision, and
 - b. the benefits that would be provided under all Other Plans without provisions similar to this provision would exceed those Allowable Expenses.
2. Except as provided in 3. and 4. below, the benefits payable under this Plan Document for Allowable Expenses incurred by a Covered Individual will be reduced to the extent that the sum of those reduced benefits and all of the benefits provided for those Allowable Expenses under all Other Plans will not exceed the total of those Allowable Expenses or the least amount a provider will accept as payment in full.
3. The following rules are used to determine the order in which benefits are payable by the plans.
 - a. A plan that has no coordination of benefits provision pays before a plan that has a coordination of benefits provision.
 - b. A plan on which the Covered Individual is a Member pays before a plan on which the Covered Individual is a dependent.
 - c. The plan that covers the individual as an active employee pays before the plan that covers the individual as a retiree.
 - d. A plan on which the Covered Individual is the Child of a Member whose birthday occurs first after the beginning of a Calendar Year pays before a plan on which the Covered Individual is the Child of a Member whose birthday occurs second after the beginning of a Calendar Year, except that:
 - (1) When the parents are separated or divorced and the parent with custody of the Child has not remarried, the plan that covers the Child as a dependent of the parent with custody pays first;

- (2) When the parents are divorced and the parent with custody of the Child has remarried, a plan which covers the Child as a dependent of the parent with custody pays before a plan which covers the Child as a dependent of the stepparent, and a plan which covers the Child as a dependent of the stepparent pays before a plan which covers the Child as a dependent of the parent without custody;
- (3) Regardless of (1) and (2) above, if there is a court decree which establishes a parent's financial responsibility for the Child's health care expenses, the court decree shall prevail.

e. When the above rules do not establish the order of payment, the plan on which the Covered Individual has been enrolled for the longest period of time pays first.

In no event will the Covered Individual be entitled to benefits from The Plan in excess of those that the Covered Individual would have received if no Other Plan benefits were available.

C. HEALTH MANAGEMENT ORGANIZATION (HMO) LIMITATION AND EXCLUSION

1. Services provided through the HMO provider network or facility

Coordination of Benefit provisions of this Plan are excluded for Health Maintenance Organization plans when a Member is also a Member of the Health Maintenance Organization, whether as a Member or Dependent, whether the HMO is qualified or not, regardless of the model of the Health Maintenance Organization. This provision applies to all HMO plans, regardless of the HMO plan design, out of pocket or co-payment provisions. This provision applies to benefits that are covered, to any extent, by the HMO. This provision does not apply when the HMO excludes a service or supply and the benefits of this Plan Document allow that service or supply. All such claims must be submitted to this Plan with a denial from the HMO clearly stating the reason for the denial of services, when services are provided through the Health Maintenance Organization provider network or facility, whether through a contracting arrangement or at a fully owned Health Maintenance Organization facility. Any benefits provided by a Health Maintenance Organization as stated above are excluded from coordination with this Plan.

2. Services not provided through the HMO provider network or facility

Dependents with primary HMO coverage will be subject to the limitations shown on Exhibit "L".

D. RESPONSIBILITY FOR TIMELY NOTICE

The Plan is not responsible for Coordination of Benefits unless timely information has been provided by another party regarding the application of this provision. It is ultimately the Member's responsibility to notify the Plan of any other coverage including

Medicare. If this notification is not done, the Member may be liable for monies overpaid by this Plan.

E. REASONABLE CASH VALUE

When an Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered to be a benefit paid. The reasonable cash value of any service provided to the Covered Individual by any organization will be considered expense incurred by that individual, and the liability of this Plan will be reduced accordingly.

F. RECOVERY FROM OTHER PLANS

Whenever payments, which should have been made under this Plan Document, have been made under any Other Plan, The Plan will have the right to pay to that Other Plan any amount The Plan determines to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Plan Document, and that payment will fully satisfy liability under this provision.

PART TEN: SUBROGATION

For any illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party, the Plan will advance the benefits of this Plan Document to the Member subject to the following:

A. LIENS

1. The Plan shall automatically have a lien, to the extent of benefits advanced, upon any recovery, whether by settlement, judgment or otherwise, that the Member receives from the third party, the third party's insurer, or the third party's guarantor. The lien shall be in the amount of paid benefits paid by The Plan under this Plan Document for the treatment of the illness, disease, injury or condition for which the third party is liable, in first priority. The Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Plan Member.
2. The Member agrees to advise The Plan, in writing, within 60 days of his or her claim against the third party and to take such action, furnish such information and assistance, and execute such papers as The Plan may require to facilitate enforcement of its rights. The Member also agrees to take no action that may prejudice the rights or interests of The Plan under this Plan Document. Failure of the Member to give such notice to The Plan or cooperate with The Plan, or actions of the Member that prejudice the rights or interests of The Plan, will be a material breach of this Plan Document and will result in the Member being personally responsible for reimbursing The Plan.
3. If The Plan needs legal authority to enforce its lien, the Member shall reimburse The Plan for the reasonable costs of collection including attorney's fees.

B. RIGHT OF RECOVERY

Whenever payments for covered benefits have been made by The Plan and those payments are more than the maximum payment necessary to satisfy the intent of this provision, regardless of who was paid, The Plan has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan or any other organizations or persons.

If a covered person or dependent receives any recovery, by way of judgement, settlement or otherwise, from any other person or business entity, the covered person or dependent agrees to reimburse the plan in full, in first priority, for any medical or disability expenses paid by it (i.e., the plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the plan Member).

PART ELEVEN: APPEAL RIGHTS

The Health Benefit Plan Document provides that treatment or service must be Medically Necessary and be covered by the program. The fact that your attending physician may prescribe, order, recommend or approve a service or treatment does not, of itself, make it Medically Necessary or make the service or treatment an allowable expense, even if it is not specifically listed as an exclusion. The San Diego County Schools Fringe Benefits Consortium has the responsibility for determining whether claims are payable. The Pacific Foundation for Medical Care Peer Review Committee must agree if the denial is based on lack of medical necessity.

Action on your plan, including any denial, and reasons for denial, will be given in writing within 90 days after the Consortium receives the claim. (The period will be extended if notification was given that additional time was needed to make a decision.)

- APPEAL PROCEDURE

If a Member does not agree, either the Member or the Member's attending physician, acting as the Member's authorized representative, may request reconsideration. This request must be made in writing within 60 days of the denial of the claim and must give the reasons the appealing party believes the denied claim should be paid. The Member and/or the Physician are entitled to review all documents pertinent to the denial of the claim.

If the Consortium either affirms the original denial of the claim, or fails to respond within 60 days after receiving the request for reconsideration (or within 120 days, if within the first 60 days notification was given that additional time is needed) and the Member still disagrees, the Member may initiate the final step of binding arbitration or small claims action if the dispute is within the jurisdictional limit of the Small Claims Court. This final step must be initiated within 90 days of receiving the final denial or the time for responding by the Consortium has expired.

PART TWELVE: BINDING ARBITRATION

Any dispute regarding a claim within the jurisdictional limits of the Small Claims Court will be resolved in such court. If the amount in dispute exceeds the jurisdictional limits of the Small Claims Court the Member must initiate arbitration in accordance with California law and in compliance with the rules established by the American Arbitration Association. This request for arbitration must be in writing to the Consortium. The applicant is responsible for the administrative filing fee as established by the American Arbitration Association. Small claims service or request for arbitration shall be made to:

**San Diego and Imperial County Schools
Fringe Benefits Consortium
6401 Linda Vista Road, Room 505
San Diego, CA 92111-7399**

Under this plan the Member has substituted their right to trial by court or jury with binding arbitration as to the dispute.

PART THIRTEEN: CONDITIONS OF ENROLLMENT

A. ELIGIBILITY

1. Member Eligibility

The Participating School District determines which employees are eligible to enroll as Members, as outlined in Exhibit "M".

2. Family Member Eligibility

The following persons are eligible for coverage as Family Members of the Member:

- a. the lawful Spouse of opposite sex or lawful Domestic Partner or as described in Part One Definitions
- b. unmarried dependent Children to the 19th birthday
- c. unmarried dependent Children from the 19th birthday to the maximum age allowed who qualify as dependents as shown in Exhibit "N". The Plan must receive yearly verification information in writing
- d. an unmarried dependent Child (i.e., grandchild) to age 19 when a covered Member has been appointed legal guardian and when the child lives with and depends on the Member for care and support
- e. unmarried dependent Children enrolled before the maximum age shown in Exhibit "N" who, upon reaching the maximum age allowed, depend on the Member for support and are incapable of self-sustaining employment because of mental retardation or physical impairment that occurred prior to reaching the age limit for unmarried dependent Children. Review Part One of

Definitions for Total Disability of Children. A Physician must certify this disability in writing. This certification must be received by The Plan within 31 days of the Child's maximum age birthday. Two years after the Child's 27th birthday The Plan may request proof of continuing dependency and disability, but not more often than yearly.

- f. domestic partners as defined and listed in Exhibit "O"
- g. The Plan will honor appropriately completed "Qualified Medical Child Support Orders (QMCSO) received from the District. As directed by the QMCSO, the Child(ren) to whom the order applies will be enrolled as dependent(s) of the employee.

3. Evidence of Insurability

A Member or dependent of Member who does not enroll when first eligible, or a new spouse/domestic partner who does not enroll within 31 days of marriage, may be required to show satisfactory evidence of good health, at the Member's expense, when application is made for enrollment. This provision also applies to newborn children and overage dependents. (Except at the Plan's open enrollment or as a result of a change in family status as defined in Internal Revenue Code, section 125.)

B. APPLICATION FOR ENROLLMENT

1. Filing of Enrollment Applications

- a. Every person eligible to enroll as a member of the San Diego County Schools Fringe Benefits Consortium must file an enrollment application with The Plan.
- b. Every person eligible to enroll as a Member must file an application with The Plan within a time period ending 31 days after becoming eligible for coverage. This application must include any eligible Family Members for whom application is being filed.
- c. The Member must file an application with The Plan to enroll a new Spouse/Domestic Partner within a time period ending 31 days after marriage or legal contract.
- d. The Member must file an application with The Plan to enroll a newly acquired Child(ren) within a time period ending 31 days after the birth or the acquiring of the Child(ren).
- e. The Plan will honor appropriately "Qualified Medical Child(ren) Support Orders" (QMCSO) received from the District. As directed by the QMCSO, the Child(ren) to whom the order applies will be enrolled as dependent(s) of the employee.
- f. The Plan reserves the right to request proof of eligibility.

2. Any application not filed within the time limits stated above must be submitted to The Plan with a health statement. The application and the health statement require The Plan's underwriting approval. This provision does not apply when there is a family status change as defined in Internal Revenue Code, section 125.

3. The District is responsible for forwarding all enrollment applications to The Plan.
4. All of the persons eligible to be Members who are not enrolled under another Group-sponsored plan must be enrolled as Members. If the number of Members enrolled through a Participating School District falls below 100 percent of the persons eligible to enroll as Members, The Plan may cancel the coverage of that Participating School District.

C. EFFECTIVE DATES

The Effective Date of Coverage is as follows:

1. Member's Effective Date

- a. For a person enrolled as a Member on the Plan Document Date, coverage begins on the Plan Document Date.
- b. For a person who files an application to enroll as a Member within the time limit stated above under Filing of Applications, coverage begins as shown on Exhibit "M" following The Plan underwriting approval.
- c. For a person who does not file an application to enroll as a Member within the time limit stated above under Filing of Applications, coverage begins on the first day of the month following The Plan underwriting approval except during normal open enrollment periods of the Member district or as a result of any family status change as described in Internal Revenue Code, section 125.

2. Family Member's Effective Date

- a. If the application of a person enrolling as a Member includes application for an eligible Spouse/Domestic Partner or Child, coverage for that Spouse/Domestic Partner or Child begins on the Member's Effective Date.
- b. For a new Spouse/Domestic Partner of a Member who is already enrolled under this Plan Document, coverage begins on the first day of the month following marriage, but only if an application to enroll the Spouse/Domestic Partner has been filed within 31 days of marriage.
- c. For a newly acquired Child of a Member who is already enrolled under this Plan Document, coverage begins on the first day of the month after acquiring the Child, but only if an application to enroll the Child has been filed within 31 days of acquiring the Child.
- d. For a Child born to a Member or Spouse/Domestic Partner who is already enrolled under this Plan Document, coverage begins at birth, in accordance with the effective date information.
- e. For a Spouse/Domestic Partner or Child for whom the Member does not file an application within the time limits stated above under Filing of Applications, coverage begins on the first day of the month following The Plan's underwriting approval. Underwriting approval is not required during

normal open enrollment of the Member district or as a result of a family status change as defined in Internal Revenue Code 125.

PART FOURTEEN: SUMMARY PLAN DESCRIPTION

- Individual Summary Plan Description Brochures

The Plan provides a Summary Plan Description brochure to the District for each Member. The brochure describes the benefits to which that Member and enrolled Family Members are entitled. The Summary Plan Description brochure is a brief description of the plan and does not create or confer any rights. It is not to be construed as a substitute for the provision of the master Plan Document and does not waive or alter any of the terms of the Plan Document. If questions arise, the Plan Document will govern.

PART FIFTEEN: PREMIUM CONTRIBUTIONS

- Member Charges

1. Premium contribution charges are determined according to a formula for calculating reimbursement due under a cost-plus rating arrangement. The formula is based on reimbursement for claims paid plus administration charges.
2. The District will reimburse The Plan for claims paid according to the terms of the San Diego County Schools Fringe Benefits Consortium Agreement.
3. The District is responsible for supplying up-to-date eligibility information. The Plan may rely upon the latest information received as correct without verification.

PART SIXTEEN: CANCELLATION OF COVERAGE

- A. Either The Plan or the District may cancel this Plan Document by giving written notice to the other party in accordance with the guidelines outlined in the San Diego County Schools Fringe Benefits Consortium Agreement. If no written notice is given, the Plan Document renews on the same terms and conditions.
- B. If premium contributions due are not paid by the end of the grace period. Cancellation is effective on the last day of the grace period.
- C. No written notice is sent to the Member when coverage is cancelled. A Member's coverage is cancelled under the following conditions:
 1. Member

- a. On the date this Plan Document between the District and The Plan is cancelled, or
- b. On the next premium contribution due date after the Member no longer meets the eligibility requirements established by the District and San Diego County Schools Fringe Benefits Consortium, or
- c. At the end of the period for which premium contributions charges have been paid when the required premium contributions for the next period are not paid, or
- d. On the next premium contributions due date after The Plan receives written notice of the Member's voluntary cancellation of coverage.

If premium contributions are paid, coverage may continue for a Member who is granted a temporary leave of absence up to six months, a sabbatical year's leave of absence up to twelve months, or an extended leave of absence due to illness certified annually by the District.

2. Spouse/Domestic Partner

- a. On the date the Member's coverage is cancelled or
- b. On the next premium contribution due date after final decree of divorce, annulment or dissolution of marriage, or
- c. At the end of the period for which premium contribution charges have been paid when the required premium contributions for the next period are not paid.

3. Child

- a. On the date the Member's coverage is cancelled, or
- b. On the next premium contribution charge due date after the Child age 19 or over no longer qualifies as a dependent as outlined in Exhibit "N", or
- c. On the next premium contribution due date after marriage, or
- d. At the end of the period for which premium contributions have been paid when the required premium contributions for the next period are not paid.

NOTE: Member, Spouse/Domestic Partner, and Child may qualify for COBRA continuation coverage if there has been a qualifying event. (See COBRA section of this Plan Document.)

PART SEVENTEEN: CONVERSION

There are no conversion rights under this Plan upon termination of eligibility or termination of the Health Plan.

PART EIGHTEEN: GENERAL PROVISIONS

A. FORM OR CONTENT OF PLAN AGREEMENT

1. The entire agreement between the parties consists of:
 - a. The San Diego and Imperial County Schools Fringe Benefits Consortium Agreement, and
 - b. This Plan Document, and
 - c. The Board Resolutions and/or Actions of the Participating District, and
 - d. The individual enrollments of eligible persons.
2. No agent of The Plan may change this Plan Document or waive any of its contents. No change in this Plan Document is valid unless the change is by endorsement signed by the Superintendent of San Diego County Schools.

B. WORKERS' COMPENSATION INSURANCE

This Plan Document does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance nor does it provide benefits that are the liability under any workers' compensation law.

C. PROTECTION OF COVERAGE

The Plan does not have the right to cancel the coverage of any Member under this Plan Document while:

1. The Plan Document is still in effect, and
2. The Member is still eligible, and
3. The Member's premium contributions are paid according to the terms of this Plan Document.

D. MAILING ADDRESSES

Any notice required of The Plan in the Plan Document will be mailed to the address as shown on The Plan records:

San Diego and Imperial County Schools
Fringe Benefits Consortium
6401 Linda Vista Road, Room 505
San Diego, CA 92111-7399

E. CLERICAL ERRORS

Clerical errors of The Plan do not deprive any Member of his or her coverage under this Plan Document. Also, these errors do not create or continue coverage that would not otherwise be effective.

F. PROVIDING OF CARE

The Plan is not responsible for providing any type of Hospital, medical or similar care. Also, The Plan is not responsible for the quality of any type of Hospital, medical or similar care received.

G. NON-REGULATION OF PROVIDERS

Benefits provided under this Plan Document do not regulate the amounts charged by providers of medical care.

H. BENEFITS NOT TRANSFERABLE

Only eligible Members are entitled to receive benefits under this Plan Document. The right to benefits cannot be transferred.

I. INDEPENDENT CONTRACTORS

All providers are independent contractors. The Plan is not liable for any claim for damages connected with any injury resulting from any treatment. The Plan is not responsible for the acts or omissions of their independent contractors.

J. AVAILABILITY OF CARE

If there is an epidemic or public disaster and the Member cannot obtain care, The Plan refunds the unearned part of the premium contributions paid for that Member. A written request for that refund and satisfactory proof of the need for care must be sent to The Plan within 31 days. This payment fulfills the obligation of The Plan under this Plan Document.

K. MEDICAL NECESSITY

The benefits of this Plan Document are provided only for services that are Medically Necessary as determined by The Plan. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition. It must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States. When an inpatient stay is necessary, services are limited to those that could not have been performed prior to admission.

L. EXPENSE IN EXCESS OF BENEFITS

The Plan is not liable for any expense the Member incurs in excess of the benefits of this Plan Document.

M. AREA OF SERVICE

The benefits of this Plan Document are provided for covered services received anywhere in the world, but are limited to those services defined as Medically Necessary in item "K" above.

N. PAYMENT TO PROVIDERS

The Plan pays the benefits of this Plan Document directly to Participating Hospitals and Participating Physicians. The Plan may also pay Non-Participating Hospitals and other providers of service directly when the Member assigns benefits in writing.

O. RECEIPT OF CLAIM

Properly completed forms or universally accepted medical forms itemizing the charge for the services received must be sent to, and received by The Plan, either by the Member or the provider of service. A claim must be **received** by The Plan within 3 months but never later than twelve months of the date services are rendered. The Plan will not consider, and is not liable for any benefits if claims are not received within this time period. This provision applies regardless of the reason why the claim is not received in a timely manner. It is not the Plan's responsibility to obtain a claim. It is ultimately the Member's responsibility to ensure that all claims are received within the filing limit. Fully itemized forms must be used: canceled checks, receipts or balance due statements are not acceptable. All claims must be filed in English.

P. RIGHT TO RECEIVE NECESSARY INFORMATION

The Plan reserves the right to deny any claim filed if claim and any requested substantiating information is not furnished when requested. Both claim and requested medical reports must be filed in English.

Q. PROTECTED HEALTH INFORMATION

The "Superintendent" as the administrator of the Plan or his/her designee is the custodian of records of the Plan. Any information that relates to an individual's past, present or future health or health care or payment for that care, and identified, or could be used to identify, the individual shall be protected by the custodian of records of the Plan. The protections apply whether the information is transmitted or maintained electronically, on paper or verbally. Health information is restricted to use in the plan administration functions.

The Plan will use and disclose protected health information for treatment, payment and health care operation with the individual's consent but if necessary without the individual's consent to the extent that may become necessary for the administration of the Plan.

R. RIGHT OF RECOVERY

When the amount paid by The Plan exceeds the amount for which The Plan is liable under this Plan Document, The Plan has the right to recover the excess amount. This amount may be recovered from the Member, the person to whom payment was made or any other plan or third party.

In cases where a tortfeasor or wrongdoer settles with a covered individual in good faith, without knowledge that the individual received benefits under this Plan, this Health Benefit Plan shall have full rights to recover any paid benefits under this Plan for any covered individual. The covered Member agrees to reimburse the plan in full, in first priority, for any; medical expenses paid by the Plan, i.e., the Plan shall be first reimbursed fully the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Plan Member.

S. FREE CHOICE OF HOSPITAL AND PHYSICIAN

THIS PLAN DOCUMENT IN NO WAY INTERFERES WITH THE RIGHT OF ANY PERSON ENTITLED TO HOSPITAL BENEFITS TO SELECT THE HOSPITAL OF THEIR CHOICE. THAT PERSON 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. HOWEVER, BENEFITS PAYABLE ACCORDING TO THE TERMS OF THIS PLAN DOCUMENT WILL BE DIFFERENT FOR NON-PARTICIPATING HOSPITALS OR NON-PARTICIPATING PHYSICIANS THAN THOSE BENEFITS PAYABLE FOR PARTICIPATING HOSPITALS OR PARTICIPATING PHYSICIANS.

This Plan Document is hereby approved by the San Diego County Superintendent of Schools as of the Plan Document date.

SAN DIEGO AND IMPERIAL COUNTY SCHOOLS
FRINGE BENEFITS CONSORTIUM INSURANCE SERVICES, LLC
BY THE SAN DIEGO COUNTY SUPERINTENDENT OF SCHOOLS
AS REPRESENTATIVE AND AUTHORIZED AGENT OF
THE SAN DIEGO AND IMPERIAL COUNTY SCHOOLS
FRINGE BENEFITS CONSORTIUM

By: _____
Diane Croiser

Title: Senior Director, Risk Management

Date: _____

ADMINISTRATION OF THE PLAN

PLAN SPONSOR: San Diego County Superintendent of
Schools as authorized agent for San
Diego and Imperial County Schools
Fringe Benefits Consortium
6401 Linda Vista Road #505
San Diego, CA 92111-7399

PLAN ADMINISTRATOR: San Diego and Imperial County Schools
Fringe Benefits Consortium
6401 Linda Vista Road #505
San Diego, CA 92111-7399
(858) 292-3773

EMPLOYER IDENTIFICATION NUMBER: 956000935G

PLAN NUMBER: 300

AGENT FOR SERVICE OF
LEGAL PROCESS: The Plan Administrator

EXHIBITS

ANNUAL DEDUCTIBLES

- I. Each Member shall meet a deductible amount of \$100 for covered expense incurred in a calendar year. When a family aggregate total of \$200 in deductibles has been met during any calendar year, no further deductible is required for the rest of the calendar year. Covered expenses incurred during the last three months of a calendar year that would apply toward the deductible for that year may be carried over to the next calendar year's deductible.

Borrego Springs Unified School District – Effective 07/01/89
 Fallbrook Union High School District – Effective 10/01/94
 Julian Union High School District - Effective 10/01/88
 Palomar Community College District – Effective 01/01/92
 Santee School District-Effective 2/01/95 – Terminated 01/01/00

- II. Each Member shall meet a deductible amount of \$100 for covered expense incurred in a calendar year. When a family aggregate total of \$300 in deductibles has been met during any calendar year, no further deductible is required for the rest of the calendar year. Covered expenses incurred during the last three months of a calendar year that would apply toward the deductible for that year may be carried over to the next calendar year's deductible.

Del Mar Union School District - Effective 10/01/93
 Santee School District – Effective 01/01/00 - Terminated 01/01/02
 Valley Center Union School District – Effective 10/01/91

- III. Each Member shall meet a deductible amount of \$250 for covered expense incurred in a calendar year. When a family aggregate total of \$500 in deductibles has been met during any calendar year, no further deductible is required for the rest of the calendar year. Covered expenses incurred during the last three months of a calendar year that would apply toward the deductible for that year may be carried over to the next calendar year's deductible.

MiraCosta Community College District
 Effective 10/01/90, Terminated 10/01/92
 Effective 10/01/95, Terminated 01/01/03
 Rancho Santa Fe School District – Effective 10/01/91

- IV. Each Member shall meet a deductible amount of \$250 for covered expense incurred in a calendar year. When a family aggregate total of \$750 in deductibles has been met during any calendar year, no further deductible is required for the rest of the calendar year. Covered expenses incurred during the last three months of a calendar year that would apply toward the deductible for that year may be carried over to the next calendar year's deductible.

MiraCosta Community College District – Effective 01/01/03
 Westmorland Elementary School District – Effective 10/01/03

- V. For Out-of-Network/Non-PPO Provider Covered Services only: Each Member shall meet a deductible amount of \$250 for covered expense incurred in a calendar year. When a family aggregate total of \$750 in deductibles has been met during any calendar year, no further deductible is required for the rest of the calendar year. Covered expenses incurred during the last three months of a calendar year that would apply toward the deductible for that year may be carried over to the next calendar year's deductible.

The Charter School of San Diego – Effective 7/01/04

STOP LOSS LEVELS

- I. After the Consortium Plan has paid \$2,000 in benefits for covered expenses paid at 90%, or 80% (excluding deductible), that a Member incurs during a Calendar Year, payment is provided at 100% of covered expense incurred by that Member for the remainder of the Calendar Year. Benefits for in-patient hospitalization in a PPO facility is paid at 100%. Prescription drugs and inpatient/outpatient psychiatric care do not apply toward this stop loss level. This is an individual stop loss level with no family maximum.

Borrego Springs Unified School District
 Effective 07/01/89, Terminated 04/01/00
 Julian Union High School District - Effective 10/01/88

- II. After there are \$5,000 in covered expenses per person per calendar year (excluding deductible), payment is provided at 100% of covered expense incurred by that Member for the remainder of the calendar year, except for any limits for inpatient services under mental or nervous disorders and substance abuse. Prescription drugs and carved-out psychiatric care do not apply toward this stop loss level. This is an individual stop loss level with no family maximum.

Del Mar Union School District - Effective 10/01/93
 MiraCosta Community College District
 Effective 10/01/90, Terminated 10/01/92
 Effective 10/01/95
 Rancho Santa Fe School District - Effective 10/01/91
 Santee School District – Effective 01/01/00 - Terminated 01/01/02
 Valley Center Union School District – Effective 10/01/91

- III. After the Consortium Plan has paid \$5,000 in benefits for covered expenses paid at 90%, or 70% (excluding deductible), that a Member incurs during a calendar year, payment is provided at 100% of covered expense incurred by that Member for the remainder of the calendar year. Prescription drugs and carved-out psychiatric care do not apply toward this stop loss level. This is an individual stop loss level with no family maximum.

Borrego Springs Unified School District - Effective 04/01/00
 Palomar Community College District – Effective 01/01/92
 Fallbrook Union High School District – Effective 10/01/94 – Terminated 10/01/02
 MiraCosta Community College District – Effective 10/01/95 – Terminated 01/01/03
 Santee School District – Effective 1/01/00 - Terminated 01/01/02

- IV. After the Consortium Plan has paid \$5,000 in benefits for covered expenses paid at 80% or 60% (excluding deductible), that a Member incurs during a calendar year, payment is provided at 100% of covered expense incurred by that Member for the remainder of the calendar year. Prescription drugs and carved-out psychiatric care do not apply toward this stop loss level. This is an individual stop loss level with no family maximum.

Fallbrook Union High School District – Effective 10/01/02

- V. Once a member has reached the annual out of pocket maximum of \$2,500 (\$5,000 per family) in covered expenses per Calendar Year, payment is provided at 100% of covered expenses incurred by that Member for the rest of the Calendar Year. The annual out of pocket maximum excludes any dollar copays, deductibles, non-covered expenses, prescription drugs, mental health and substance abuse charges and any other charge determined to exceed The Plan allowable for Non-PPO providers.

MiraCosta Community College District – Effective 10/01/95

- VI. After the Member has paid a yearly \$1,000 out-of-pocket maximum for covered expenses provided by Participating Hospitals, Participating Physicians, or Providers, then the Plan pays 100%. For covered expenses provided by Non-Participating Hospitals, Non-Participating Physicians, or Related Health Providers, the Member's out-of-pocket maximum is \$2,000, then the Plan pays 100%.

Westmorland Elementary School District – Effective 10/01/03

CHIROPRACTIC AND ACUPUNCTURE BENEFITS

- I. Benefits for Chiropractic and Acupuncture care/treatment are limited to \$50 per visit and/or a \$1,000 maximum for services rendered in a Calendar Year.

Del Mar Union School District - Effective 10/01/93
Fallbrook Union High School District - Effective 10/01/94
MiraCosta Community College District
Effective 10/01/90, Terminated 10/01/92
Effective 10/01/95
Palomar Community College District - effective 01/01/92
Rancho Santa Fe School District - Effective 10/01/91
Santee School District – Effective 01/01/00 - Terminated 01/01/02
Valley Center Union School District – Effective 10/01/91

- II. Benefits for Chiropractic and Acupuncture care/treatment are paid at 90% when using a Participating Provider and 80% when using a Non-Participating Provider.

Borrego Springs Unified School District - Effective 7/1/89
Julian Union High School District - 10/1/88

- III. Benefits for Chiropractic and Acupuncture care/treatment are paid at 90% when using a Participating Provider, and 70% when using a Non-Participating Provider. All covered expenses are limited to \$50 per visit up to \$1,000 maximum for services rendered in a Calendar Year.

Westmorland Elementary School District – Effective 10/01/03

- IV. **CHIROPRACTIC:** Not covered unless all services are obtained through American Specialty Health Plans (ASHP). Member pays a \$10 co-payment per visit. Visits are limited to 30 visits per calendar year.

ACUPUNCTURE: Payment is provided for 100% of the negotiated rate for a covered expense incurred by that Member for all covered services provided by a Participating Physician or Provider, after a \$10 co-payment per office visit OR payment is provided for 80% of the allowable charge for a covered expense incurred by that Member for all covered services provided by a Non-Participating Physician or Related Health Provider, after deductible is met. Visits are limited to 30 visits per calendar year combined in and out-of-network.

The Charter School of San Diego – Effective 7/01/04

MAXIMUM BENEFITS

I. \$1,000,000 lifetime maximum benefit

Borrego Springs Unified School District - Effective 07/01/89, Terminated 10/01/02
 Del Mar Union School District - Effective 10/01/93, Terminated 10/01/02
 Rancho Santa Fe School District - Effective 10/01/91, Terminated 10/01/02
 Valley Center Union School District – Effective 10/01/91, Terminated 10/01/02

II. \$2,000,000 lifetime maximum benefit

Fallbrook Union High School District - Effective 10/01/94 – Terminated 09/30/04
 MiraCosta Community College
 Effective 10/01/90, Terminated 10/01/92
 Effective 10/01/95 – Terminated 09/30/04
 Palomar Community College District – Effective 01/01/92 – Terminated 09/30/04
 Santee School District – Effective 02/01/95 - Terminated 01/01/02
 Borrego Springs Unified School District - Effective 10/01/02 –
 Terminated 09/30/04
 Del Mar Union School District - Effective 10/01/02 – Terminated 09/30/04
 Rancho Santa Fe School District - Effective 10/01/02 – Terminated 09/30/04
 Valley Center Union School District – Effective 10/01/02 – Terminated 09/30/04
 Westmorland Elementary School District – Effective 10/01/03 –
 Terminated 09/30/04
 The Charter School of San Diego – Effective 7/01/04 – Terminated 09/30/04

III. Unlimited lifetime maximum benefit

Julian Union High School District - Effective 10/01/88 – Terminated 09/30/04

IV. \$5,000,000 lifetime maximum benefit

Borrego Springs Unified School District – Effective 10/01/04
 Charter Schools of San Diego – Effective 10/01/04
 Fallbrook Union High School District – Effective 10/01/04
 Imperial Unified School District – Effective 10/01/04
 Julian Union High School District – Effective 10/01/04
 MiraCosta Community College – Effective 10/01/04
 Palomar Community College – Effective 10/01/04
 Rancho Santa Fe School District – Effective 10/01/04
 Valley Center-Pauma Unified School District – Effective 10/01/04
 Westmoreland Elementary School District – Effective 10/01/04

V. \$25,000 lifetime maximum for inpatient mental or nervous disorders.

Fallbrook Union High School District - Effective 10/01/90 – Terminated 10/01/02

Valley Center Unified School District - Effective 10/01/91 – Terminated 10/01/02

VI. Unlimited lifetime maximum for inpatient/outpatient mental and nervous and substance abuse. Administered by Vista Behavioral as a carve-out program.

Julian Union High School District - Effective 10/01/88

Borrego Springs Unified School District - Effective 07/01/89

Rancho Santa Fe School District - Effective 10/01/91

MiraCosta Community College District – Effective 10/01/95

Palomar Community College District – Effective 01/01/98

Del Mar Union School District – Effective 10/01/00

Santee School District - Effective 01/01/98 - Terminated 01/01/02

Fallbrook Union High School District - Effective 10/01/02

Valley Center Unified School District - Effective 10/01/02

Westmorland Elementary School District – Effective 10/01/03

PRE-EXISTING CONDITIONS

- I. All Members enrolling after the Effective Date of this Plan (as described in Plan Document) shall be excluded from any benefit for any conditions for which treatment was received during the ninety days (90) immediately preceding the Member's Effective Date. This provision also applies to newly adopted children and newly acquired spouses/domestic partners. This limitation ceases to apply to any Member after twelve consecutive months of Membership in the Plan.

Del Mar Union School District - Effective 10/01/93
Fallbrook Union High School District – Effective 10/01/94
MiraCosta Community College District
Effective 10/01/90, Terminated 10/01/92
Effective 10/01/95
Palomar Community College District – Effective 01/01/92
Rancho Santa Fe School District - Effective 10/01/91
Santee School District – Effective 01/01/00 - Terminated 01/01/02
Valley Center Union School District – Effective 10/01/91
Westmorland Elementary School District – Effective 10/01/03

- II. All Members enrolling after the Effective Date of this Plan (as described in the Plan Document) are subject to a \$1,000.00 maximum benefit for any condition for which treatment was received during the ninety days (90) immediately preceding the Member's effective date. This provision also applies to newly adopted children and newly acquired spouses/domestic partners. This limitation ceases to apply to any Member after twelve consecutive months of Membership in the Plan.

Santee School District
Effective 02/10/97 Terminated 01/01/00

- III. All Members enrolling after the Effective Date of this Plan are not subject to any benefit reduction for a pre-existing condition.

Borrego Springs Unified School District - Effective 07/0/89
Julian Union High School District - Effective 10/01/88
The Charter School of San Diego – Effective 7/01/04

EMERGENCY ROOM COPAYMENT

I. Each hospital emergency room use requires a co-payment of \$25.00

Palomar Community College District – Effective June 1, 1993

II. Each hospital emergency room use requires a co-payment of \$50.00

Del Mar Union School District – Effective 10/01/93

Fallbrook Union High School District – Effective 10/01/94

MiraCosta Community College District – Effective 10/01/95

Rancho Santa Fe School District – Effective 10/01/91

Santee School District – Effective 01/01/00 - Terminated 01/01/02

Valley Center School District – Effective 01/01/00

III. There is no emergency room co-payment.

Borrego Springs Unified School District- Effective 07/01/89

Julian Union High School District - Effective 10/01/88

IV. Each hospital emergency room use requires a co-payment of \$50.00. If services are provided by a Participating Hospital, then the Plan pays 90% or 70% for services are provided by a Non-Participating Hospital.

Westmorland Elementary School District – Effective 10/01/03

V. Each In-Network hospital emergency room use requires a co-payment of \$50. If admitted, the co-payment is waived. Out-of-Network/Non-PPO hospital emergency room use will be covered at 80% after deductible.

The Charter School of San Diego – Effective 7/01/04

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

- I. Outpatient and inpatient mental and nervous disorders and substance abuse are covered through an insured contract: **Vista Behavioral Health Plan (800)468-5667**
(A Division of Magellan Behavioral Health)

Borrego Springs Unified School District
Del Mar Union School District
Fallbrook Union High School District
Julian Union High School District
MiraCosta Community College District
Palomar Community College District
Rancho Santa Fe School District
Santee School District - Terminated 01/01/02
Valley Center Unified School District
Westmorland Elementary School District
The Charter School of San Diego

PREVENTIVE CARE LIMITS

- I. Well baby care and routine physical examinations and related laboratory and X-ray procedures in accordance with the American Medical Association guidelines and/or the American Pediatric Society, are a paid benefit up to a maximum of \$100.00 in a Calendar Year. Dependent children immunizations are not subject to the \$200 annual maximums, but are an additional benefit of your Plan.

Del Mar Union School District - Effective 10/01/93

MiraCosta Community College District

Effective 10/01/90, Terminated 10/01/92

Effective 10/01/95

Rancho Santa Fe School District - Effective 10/01/91

Santee School District – Effective 02/01/95 - Terminated 01/01/02

Valley Center Union School District – Effective 10/01/91

- II. Well baby care and routine physical examinations, as above, are a paid benefit up to a maximum of \$200.00 in a calendar year. Dependent children immunizations are not subject to the \$200 annual maximums, but are an additional benefit of your Plan.

Palomar Community College District – Effective 01/01/92

Fallbrook Union High School District – Effective 10/01/94

- III. Well baby care and routine physical examinations are not a covered benefit. Mammography, pap smears, and Child immunizations are paid at 90% when using a Participating Provider and 80% when using a Non-participating Provider.

Borrego Springs Unified School District - Effective 7/1/89

Julian Union High School District - Effective 10/1/88

- IV. Well baby care and routine physical examinations for which males may include prostate cancer screening services and in accordance with the American Medical Association guidelines and/or the American Pediatric Society are a paid benefit up to a maximum of \$200 in a Calendar Year. Mammography, pap smears, and Child immunizations are paid at 90% of the negotiated rate when using a Participating Provider and 70% of the usual, reasonable, and customary when using a Non-participating Provider based on American Medical Association guidelines and/or the American Pediatric Society. Dependent children immunizations are not subject to the \$200 annual maximums, but are an additional benefit of your Plan.

Westmorland Elementary School District – Effective 10/01/03

- V. Well baby care and immunizations, routine OB-Gyn Exams, and routine physical examinations for which males may include prostate cancer screening services and in accordance with the American Medical Association guidelines are paid at **100%** after a **\$10 co-payment per visit** for services rendered by a Participating Physician or Provider; or **80% after deductible** for a Non-Participating Physician or Non-Participating Provider. A routine mammogram is paid at **100%** of the negotiated rate and when using a Participating Provider or **80%** of the usual, customary, and reasonable charges when using a Non-participating Provider based on American Medical Association guidelines.

The Charter School of San Diego – Effective 7/01/04

ADULT IMMUNIZATIONS

- I. The following districts cover immunization for the Hepatitis B vaccine series for employees Members only as required by Cal-OSHA's Regulation 5193. No deductible applies and the charges are not accrued to an employee Member's lifetime maximum.

Palomar Community College District – Effective June 1, 1993

PRESCRIPTION DRUG BENEFITS

- I. \$5.00 OR 20% co-payment, whichever is greater. The amount prescribed by physician, but not to exceed a 90-day supply for maintenance drugs. \$5.00 co-payment for a 90-day supply through mail order. All prescriptions will be filled with generic drugs. Brand name drugs can be used if requested by the Member or Physician but the Member will pay the difference between the allowed generic price and the cost of the brand name.

Mira Costa Community College District - Effective 10/01/95
Rancho Santa Fe School District - Effective 10/01/91
Santee School District – Effective 01/01/00 - Terminated 01/01/02
Valley Center Union School District – Effective 10/01/91

- II. \$5.00 co-payment for Generic - \$10.00 Co-payment for Non-Generic. The amount prescribed by a Physician but not to exceed a 30-day supply or 100-unit dose, whichever is greater. Generic required unless Physician specifically requires a brand name. \$5.00 co-pay for a 90-day supply through mail order.

Borrego Springs Unified School District - Effective 04/01/00
Fallbrook Union High School District – Effective 10/01/94

- III. \$5.00 co-payment for Generic - \$10.00 Co-payment for Non-Generic. The amount prescribed by a Physician but not to exceed a 30-day supply or 100-unit dose, whichever is greater. Generic required unless Physician specifically requires a brand name. \$5.00 co-pay for a 90-day supply through mail order. This plan also includes birth control pills.

Palomar Community College District - Effective 01/01/92

- IV. \$4.00 co-payment for Generic - \$7.00 co-payment for Non-Generic and \$5.00 for a 90-day supply through mail order. This plan includes benefits “when prescribed by a physician” for oral contraceptives, injectables and internally implanted time-release contraceptives, diaphragms, cervical caps, and intrauterine devices. Other contraceptive devices are not covered.

Del Mar Union School District – Effective 11/01/99 – Terminated 10/01/03

- V. \$10.00 co-payment for Generic - \$15.00 co-payment for Non-Generic and \$10.00 for a 90-day supply through mail order. This plan includes benefits “when prescribed by a physician” for oral contraceptives, injectables and internally implanted time-release contraceptives, diaphragms, cervical caps, and intrauterine devices. Other contraceptive devices are not covered.

Del Mar Union School District – Effective 10/01/03

- VI. \$3.00 co-payment for Generic or Non-Generic and \$5.00 for a 90-day supply through mail order

Julian Union High School District - Effective 10/01/88

- VII. \$5.00 co-payment for Generic, \$10.00 co-payment for Preferred Brand Name, and \$25 co-payment for Non-Preferred Brand. The amount prescribed by a Physician but not to exceed a 30-day supply or 100-unit dose, whichever is greater. Generic required unless Physician specifically requires a brand name. A 90-day supply of maintenance prescriptions is available with a \$10.00 co-payment for Generic, \$20.00 co-payment for Preferred Brand Name, and \$50 co-payment for Non-Preferred Brand. This plan also includes birth control pills.

Westmorland Elementary School District – Effective 10/01/03

- VIII. \$5.00 co-payment for Generic - \$10.00 Co-payment for brand name. The amount prescribed by a Physician but not to exceed a 30-day supply or 100-unit dose, whichever is greater. Generic required unless Physician specifically requires a brand name. \$5.00 co-payment for Generic - \$10.00 Co-payment for brand name for a 90-day supply through mail order. This plan also includes birth control pills.

The Charter School of San Diego – Effective 7/01/04

MEDICARE BENEFITS

- I. For all Medicare-eligible retirees, San Diego County Schools Fringe Benefits Consortium Health Plan provides the benefits of this Plan Document less any benefits to the extent that the retired Member is entitled to receive Medicare benefits whether or not Medicare benefits are actually paid. Normal Coordination of Benefit rules applies.

Borrego Springs Unified School District - 7/1/89
Del Mar Union School District - Effective 10/01/93
Julian Union High School District - Effective 10/01/88
MiraCosta Community College District
Effective 10/01/90, Terminated 10/01/92
Effective 10/01/95
Rancho Santa Fe School District - Effective 10/01/91
Santee School District – Effective 02/01/95 - Terminated 01/01/02
Valley Center Union School District – Effective 10/01/91

- II. For all Medicare-eligible retirees after June 30, 1991, San Diego County Schools Fringe Benefits Consortium Health Benefit Plan provides the benefits of this Plan Document less any benefits to the extent that the retired Member is entitled to receive Medicare benefits whether or not Medicare benefits are actually paid. For Retirees prior to June 30, 1991 who do not have enough quarters to qualify them for Medicare benefits whether or not Medicare benefits are actually paid. For Retirees prior to June 30, 1991 who do not have enough quarters to qualify them for Medicare benefits without cost, this plan will pay primary for the lifetime of the retired Member for Medicare Part B only.

Palomar Community College District – Effective 01/01/92

- III. For all Medicare eligible retirees who retired prior to June 1, 1991, this plan pays primary to all other plans, including Medicare.

Palomar Community College District

HEALTH MAINTENANCE ORGANIZATION LIMITATIONS

- I. No additional special limitations apply to dependent spouse/domestic partner or child who have primary coverage through an HMO.

Del Mar Union School District – Effective 10/01/93
Julian Union High School District – Effective 10/01/88
MiraCosta Community College District
Effective 10/01/90, Terminated 10/01/92
Effective 10/01/95
Palomar Community College District – Effective 01/01/92
Santee School District – Effective 02/01/95 – Terminated 01/01/02
Valley Center Union School District – Effective 10/01/91
Westmorland Elementary School District – Effective 10/01/03
The Charter School of San Diego – Effective 7/01/04

- II. If a Dependent spouse/domestic partner or child has primary coverage through an HMO, the spouse/domestic partner or dependent will be required to obtain all medical care through that HMO – the HMO will always be primary. This Plan requires a Member to use their HMO for all services. If an HMO does not cover a service or supply, and is covered by this Plan, all of the HMO’s pre-authorizations and claims requirements must be fulfilled and complete HMO denial documentation must be provided before this Plan will consider application of this Plan’s benefit. If the HMO requirements are not fulfilled completely, there will be no benefits available under this Plan. Additionally, this Plan does not coordinate benefits with any HMO. Any out-of-pocket expense after an HMO has provided a benefit is not eligible for reimbursement under this Plan. The San Diego County Schools Fringe Benefits Consortium Health Benefit Plan shall pay secondary based on the assumption that the HMO paid primary whether HMO services were used or not.

Borrego Springs Unified School District - Effective 04/01/00
Rancho Santa Fe School District – Effective 10/01/91

ELIGIBILITY

MEMBER DISTRICT	ELIGIBILITY	ELIGIBILITY DATE
Borrego Springs Unified School District Effective 07/01/89	All active, full-time and permanent part-time employees working 20 hours or more per week, and Board Members and early retirees. Benefits terminate for retirees at age 65.	The first day of the month after the date of hire.
Del Mar Union School District Effective 10/01/89 Change 03/01/01	All active, full-time and permanent part-time employees working 20 hours or more per week, and Board Members and early retirees. Benefits terminate for retirees at age 65.	If hire date is from the 1 st to the 15 th , eligibility is effective the first of the next month. If hire date is the 16 th to the 31 st , eligibility occurs the 1 st of the month after (Example: hired 9/8 eligible 10/1; hired 9/16 eligible 11/1)
Fallbrook Union High School District Effective 10/01/88 Change 10/01/94	All active, full-time and permanent part-time employees working 20 hours or more per week, and Board Members as well as Board approved early retirees. Benefits terminate for retirees at age 65.	The first day of the month after date of hire.
Julian Union High School District Effective 10/01/88	All active, full-time and permanent part-time employees working 20 hours or more per week. All retirees and Board Members. Benefits terminate for retirees at age 65.	The first day of the month after date of hire.
MiraCosta Community College District Effective 10/01/90 Terminated 10/01/92 Effective 10/01/95	All active, full-time employees working more than 20 hours per week. All retirees to age 65 per district board policy. Benefits terminate for retirees at age 65.	The first day of the month after date of hire.
Palomar Community College District Effective 01/01/92	All active, full-time employees working more than 20 hours per week and Board Members. All retirees to age 65 if retired after 6/30/91. For retirees before 6/30/91 who do not have enough	The first day of the month after date of hire.

	quarters to qualify for Part A, this plan pays primary for Part A only of Medicare coverage.	
Rancho Santa Fe School District Effective 10/01/91	All active, full-time employees working more than 20 hours per week and retirees over age 65, with Board approval. Benefits terminate for retirees at age 65.	The first day of the month after date of hire.
Santee School District Effective 10/01/89 Terminated 01/01/94 Reinstated 02/01/95 Terminated 01/01/02	All active, full-time and part-time certificated employees working 20 hours or more including early retirees. Benefits terminate for retirees at age 65.	The first day of the month after date of hire.
The Charter School of San Diego Effective 7/01/04	An active employee in paid status in a monthly-salaried position of half-time or more is eligible for this Health Plan.	The first day of the month following the first day of paid service in a monthly salaried position of half-time or more, provided the employee is actively at work and the appropriate enrollment forms are received in the HR department within 31 days of eligibility for coverage.
Westmorland Elementary School District Effective 10/01/03	All active, full-time permanent employees.	The first day of the month after the date of hire.
Valley Center-Pauma Union School District Effective 10/01/91	All active, full-time and part-time employees working more than 20 hours per week including early retirees. Benefits terminate for retirees at age 65.	If hire date is from the 1 st to the 15 th , eligibility is effective the first of the next month. If hire date is the 16 th to the 31 st , eligibility occurs the 1 st of the month after (Example: hired 9/8 eligible 10/1, hired 9/16 eligible 11/1).

All retirees eligible for health and welfare benefits are provided for under Section 7000 of the Education Code (AB528), and those additional retirees the district extends this benefit to.

OVERAGE DEPENDENT ELIGIBILITY

- I. Unmarried Children from the 19th to the 23rd birthday who qualify as full-time students (Full-time student status is considered equivalent to 12 units of credit).
- Del Mar Union School District – Effective 10/01/93-Terminated 10/1/99
MiraCosta Community College District
Effective 10/01/90, Terminated 10/01/92
Rancho Santa Fe School District – Effective 10/01/91
Valley Center School District – Effective 10/01/91 - Terminated 10/01/00
- II. Unmarried Children from the 19th to the 25th birthday who qualify as full-time students (Full-time Student status is considered equivalent to 12 units of credit).
- Del Mar Union School District - Effective 10/01/99
Fallbrook Union High School District – Effective 10/01/94
Palomar Community College District – Effective 01/01/92
MiraCosta Community College District – Effective 10/01/95
Santee School District – Effective 02/01/95 - Terminated 01/01/02
Westmorland Elementary School District – Effective 10/01/03
- III. Unmarried Children from the 19th to the 25th birthday who either qualify as full-time students (Full-time Student status is considered equivalent to 12 units of credit) or as dependents as defined by the Internal Revenue Code for federal income tax purposes.
- Borrego Springs Unified School District - Effective 7/1/89
Julian Union High School District - Effective 10/01/88
Valley Center-Pauma School District - Effective 10/01/00
- IV. At age 19, unmarried Children may be included to age 25 as dependents if they maintain full-time student status in an accredited college, university, or vocational/technical school. The vocational/technical school must be approved by the State Department of education. An unmarried enrolled Child who is at least 19 years of age, is primarily dependent upon the employee for support and maintenance, and is incapable of self-sustaining employment because of mental or physical impairment that occurred prior to reaching the age 19, may continue as a family member as long as he/she is disabled. A Physician must certify this disability in writing. This certification must be received within 31 days of the Child's maximum age birthday (age 19) and may be requested not more often than annually by the Health Plan. Dependents who are in active, full-time military service are not eligible for coverage on this Health Plan.
- The Charter School of San Diego – Effective 7/01/04

DOMESTIC PARTNER

- I. Domestic partner eligibility requires a Declaration of Domestic Partnership completion to be submitted with the application for enrollment. All requirements listed on the Declaration must be met. Domestic partners may be opposite or same sex partners. Dependents of domestic partners are also eligible and subject to the eligibility requirements outlined in Exhibit “N”. Domestic partnership requires a long-term committed relationship of at least 12 months prior to enrollment. A Notice of Termination must be filed within 30 days of termination of this relationship and a copy mailed to the domestic partner. DOMESTIC PARTNERS AND THEIR DEPENDENTS ARE NOT ELIGIBLE FOR COBRA BENEFITS.

MiraCosta Community College District – Effective 10/01/95
Palomar College – Effective 5/01/00

- II. Domestic partner eligibility requires a Declaration of Domestic Partnership completion to be submitted with the application for enrollment. All requirements listed on the Declaration must be met. Domestic partners must be same sex partners. Dependents of domestic partners are also eligible and subject to the eligibility requirements outlined in Exhibit “N”. Domestic partnership requires a long-term committed relationship of at least 12 months prior to enrollment. A Notice of Termination must be filed within 30 days of termination of this relationship and a copy mailed to the domestic partner. DOMESTIC PARTNERS AND THEIR DEPENDENTS ARE NOT ELIGIBLE FOR COBRA BENEFITS.

The Charter School of San Diego – Effective 7/01/04

HEALTH INSURANCE PORTABILITY ACT OF 1996
(HIPAA)

Federal laws regarding portability of coverage, maternity stays and mental health benefits were passed in the Health Insurance Portability Act of 1996. The law would impact your group health plan **except that the law allows for self-funded government plans to be exempt.** The federal law does, however, require us to notify you of the provisions that would have applied if the plans had not elected to be exempt. Those provisions are:

- Pre-existing Provision: The law imposes new restrictions on a group health plan’s pre-existing condition exclusions.
- Portability Provision: The law allows for a credit on prior coverage to satisfy any pre-existing condition under a new plan.
- Special Enrollment Periods: A group health plan is required to provide for special enrollment periods during which certain individuals who previously decline coverage are allowed to enroll.
- Non-discriminatory Eligibility Provisions: A group health plan generally may not establish rules for eligibility based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
- Minimum Maternity Stays: A group health plan is required to offer a minimum 48 hour hospital stay for new mothers and newborns and 96 hours for post cesarean sections.
- Mental Health Parity: A group health plan must apply the same lifetime and annual dollar limits that apply to physical health care.

YOUR BENEFITS HAVE NOT CHANGED

FEDERAL LAW REQUIRES US TO NOTIFY YOU OF THE PROVISIONS THAT WOULD HAVE APPLIED IF THE PLAN HAD NOT ELECTED TO BE EXEMPT. NO ACTION IS REQUIRED BY YOU.

PLAN AMENDMENTS

November, 1994

January, 1995

July, 1995

January 1, 1997

January 1, 2000

May, 2001

September, 2003

February 2004

March 2004