
Palomar Community College

PPO Health Plan

A Grandfathered Plan

Summary Plan Booklet



This Booklet is a summary of your District's Grandfathered Self-Funded PPO Health Plan. This summary of the Health Benefit Plan is not to be construed or accepted as a substitute for the provisions of the Plan document. Therefore, in the event of an inconsistency between the terms of this Booklet and the terms of the Plan, the terms of the Plan shall prevail over this Booklet. The Plan and this Booklet may be amended at any time.

PLEASE READ THIS BOOKLET CAREFULLY

Palomar Community College PPO Health Plan
Summary Plan Booklet
Benefit Highlights

CO-INSURANCE	MEMBER PAYS	
	In-Network Preferred Providers	Out-of-Network Providers
CALENDAR YEAR DEDUCTIBLE (all providers combined)	\$100 per individual / \$200 per family	
CALENDAR YEAR STOP-LOSS MAXIMUM	After the plan has paid \$5,000 in covered expenses per member, per calendar year, the plan will pay 100% of covered expenses incurred by that member for the rest of the calendar year.	
LIFETIME MAXIMUM BENEFIT		
Maximum lifetime benefit per member	Unlimited	

PROFESSIONAL SERVICES	MEMBER PAYS	
	In-Network Preferred Providers	Out-of-Network Providers
Visit to a physician, physician assistant or nurse practitioner	10%	30%
Routine physical examinations*	10%	30%
Well-Women care, including pap smear and mammography* (pap smear and mammography not subject to the \$200 calendar year maximum)	10%	30%
Well-baby/child care* (immunizations are not subject to the \$200 calendar year maximum)	10%	30%
Physician visit to hospital or skilled nursing facility	10%	30%
Surgeon or assistant surgeon	10%	30%
Administration of anesthetics	10%	30%
X-ray and laboratory procedures	10%	30%
*Based on frequency recommended by the American Medical Association and \$200 maximum in a calendar year.		
Outpatient Rehabilitative Therapy - Utilization review required after 30 calendar days. Speech Therapy - Limited to treatment following surgery, injury, or non-congenital disease.	10%	30%

CARE FOR CONDITIONS OF PREGNANCY (professional services only)	MEMBER PAYS	
	In-Network Preferred Providers	Out-of-Network Providers
Prenatal and postnatal office visit	10%	30%
Normal delivery, Cesarean section. Includes newborn inpatient care.	10%	30%
Complication of pregnancy, including medically necessary abortions	10%	30%
Circumcision of newborn	10%	30%

OTHER SERVICES	MEMBER PAYS	
	In-Network Preferred Providers	Out-of-Network Providers
Ground and air ambulance	10%	20%
Durable medical equipment.	10%	30%
Prosthesis	10%	30%
Blood, blood plasma, blood factors and blood derivatives	10%	30%

***Limited to a maximum \$200 benefit per calendar year.**

OTHER SERVICES (cont.)	In-Network Preferred Providers	Out-of-Network Providers
Nuclear medicine	10%	30%
Chemotherapy	10%	30%
Renal dialysis	10%	30%
Home health visit - <i>limited to 100 visits per calendar year. In and out-of-network limits combined.</i>	10%	30%
Hospice care	10%	30%

MEMBER PAYS

CHIROPRACTIC AND ACUPUNCTURE CARE	In-Network Preferred Providers	Out-of-Network Providers
Chiropractic services	10%	30%
Acupuncture services	10%	30%
	Up to \$50 per visit. Maximum \$1,000 per calendar year.	

MEMBER PAYS

HOSPITAL AND SKILLED NURSING FACILITY SERVICES	In-Network Preferred Providers	Out-of-Network Providers
Unlimited days of hospital care in a semi-private room or ICU with ancillary services	10%	30%
Confinement in skilled nursing facility	10%	30%
Maternity care. Includes routine nursery charges	10%	30%
Outpatient surgery	10%	30%
Outpatient services (except emergency room)	10%	30%

MEMBER PAYS

EMERGENCY CARE/URGENTLY NEEDED CARE	In-Network Preferred Providers	Out-of-Network Providers
Use of emergency room (facility) Co-pay waived if admitted to hospital	10% after \$25 copay	30% after \$25 copay
Use of urgent care center (facility and professional services)	10%	30%

RETAIL PRESCRIPTIONS - EXPRESS SCRIPTS RETAIL PHARMACIES

MEMBER PAYS

For a 30 day supply	
Generic	\$5
Brand	\$10

MAIL ORDER PRESCRIPTIONS - EXPRESS SCRIPTS MAIL SERVICE

MEMBER PAYS

For a 90 day supply	
Generic/Brand	\$5

OUT OF AREA

MEMBER PAYS

Out of Area refers to services received outside the United States	20% of UCR after deductible
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THIS IS ONLY A SUMMARY OF THE COVERED BENEFITS AND SERVICES. PLEASE REFER TO THIS SUMMARY PLAN BOOKLET FOR DETAILED COVERAGE INFORMATION.

Palomar Community College PPO Health Plan Summary Plan Booklet

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I. INTRODUCTION

Your Healthcare Plan – A Grandfathered Plan

Palomar Community College (the "District") is pleased to present its medical benefit plan, a comprehensive plan to help you meet the needs of your family and to help protect you from the high cost of health care services. The Plan provides medical coverage for you and your Eligible Dependents. The Plan, as described in this Booklet, represents the District's continuing interest in helping you meet your financial responsibilities for your family's health care.

This Booklet outlines eligibility requirements; services covered, and Plan limitations, as well as how to file a claim and how to find an answer when you have a question. We recommend that you read this entire Booklet because many of the topics are interrelated; reading just one or two parts may result in a misunderstanding. As you review the material, please note that words and phrases you find as defined terms are further explained in the section entitled "**Important Definitions.**" If you have any questions that do not appear to be covered in this Booklet, please contact the Plan's Customer Services/Claims Department at (858) 292-3542 or (888) 233-7915.

Preferred Provider Organization

A preferred provider organization, commonly known as a PPO, is a network of hospitals or physicians (or both) who have agreed to offer health care services at a reduced rate (the PPO provider directory is available online at www.multiplan.com or by calling (877) 942-7427).

The PPO plan option allows you to exercise control over the cost of your health care by choosing an in-network provider. For example:

- Benefits for services at Participating Hospitals, Participating Physicians and other non-hospital services rendered by a member of the PPO are provided at a discounted Negotiated Rate. These discounts translate into savings for you because your coinsurance is based on a lower dollar amount.
- Benefits for services at Non-Participating Hospitals, Non-Participating Physicians and other non-hospital services rendered by a provider that is NOT a member of the PPO network are based on the Usual, Customary and Reasonable charges. You may receive services from an out-of-network provider; however, your claims will be reimbursed at a lower rate. You will be held responsible for your coinsurance, any deductible AND for any amounts billed over the Usual, Customary, and Reasonable charges. Refer to the section entitled "**Benefit Highlights**" for specific details.

When you receive services from a PPO service provider, the provider will submit the claim to the Plan Administrator on your behalf. If services are obtained from a Non-PPO service provider, you will be responsible for submitting a fully-itemized claim to the Plan Administrator. Please review the section entitled "Receipt of Claims" listed in this Booklet under "General Provisions" for more details regarding the timeline for submitting claims.

Notification Requirement

Notification requirements are designed to ensure that you receive the most appropriate and cost-effective treatment. These requirements are described in detail in the section entitled "**Utilization Management.**" Notification does not mean benefits are payable in all cases. Coverage depends upon the covered health services that are actually provided, your eligibility status, and any benefit limitations.

Rights and Limits

This Booklet provides a general description of the Plan and your benefits. It is important to remember that:

- The description of benefits in this Booklet replaces and supersedes any other Booklet previously issued by the District for this Plan.
- All benefits are subject to the terms, conditions, and limitations of the Plan.
- No Plan provision is intended to provide employees, former employees, or Eligible Dependents with a vested right to any benefits under the Plan or any rights to continued employment.
- Your rights, if any, to benefits under the Plan depend upon whether you satisfy the eligibility requirements of the Plan and whether your submitted claims are Covered Expenses.

Presumption of Exclusion

This Plan provides for those expenses expressly described within, and any omission is presumed to be an exclusion. This Plan covers only those procedures, services, and supplies that are determined to be Covered Expenses.

Women's Health and Cancer Rights Act

This Plan complies with the Women's Health and Cancer Rights Act ("WHCRA") and provides the required benefits in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Mental Health Parity Act

This Plan complies with the Mental Health Parity Act, which generally requires parity between mental health benefits and medical/surgical benefits.

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility for Employees

All active employees, according to eligibility requirements set forth in bargaining unit contracts, Board Members, and early retirees are eligible to participate in this Plan. RETIREES MAY NOT ADD A SPOUSE OR DEPENDENTS TO THE COVERAGE AFTER RETIREMENT.

Eligibility for Dependents and Domestic Partners

Dependents eligible for Plan coverage include: (i) your Spouse or Domestic Partner (District policy allows for opposite sex domestic partnerships, but only if the two persons have been sharing a common residence for at least twelve (12) continuous months without interruption); (ii) children under age 26, unless eligible for coverage by another employer plan; (iii) unmarried dependent children whom you have adopted or who are legally placed for adoption with you; (iv) unmarried dependent children for whom you have been appointed legal guardian, but only if such children depend upon you for care and support; (v) unmarried dependent children for whom you, your Spouse or your Domestic Partner are required to provide coverage due to a Medical Child Support Order; (vi) unmarried enrolled child, incapable of self-sustaining employment because of mental or physical impairment that occurred prior to reaching the age limit for children may continue as a family member as long as disabled. A Physician must certify this disability in writing. This certification must be received within 31 days of the child's maximum age birthday and may be requested not more often than annually by the Plan.

The Plan Administrator reserves the right to request proof of eligibility.

Retirees and Spouses

Group I retirees: Benefits terminate for retirees and their Eligible Dependents at the end of the retiree's life.

Group II retirees: Benefits terminate for retirees and their Eligible Dependents at age 65 or death of the retiree, which ever occurs first.

General Enrollment

The District will provide you with information about your coverage and an enrollment form prior to the date you become eligible for coverage.

In general, you must file an enrollment application with the District for yourself (including any Eligible Dependents) within 31 days after becoming eligible under this Plan.

You must file an application to enroll a new Spouse, Domestic Partner or dependent children within 31 days of acquiring a new dependent.

Unless special enrollment rights apply, discussed below, if you or your Eligible Dependents make an application to enroll for coverage under the Plan more than 31 days from the date of eligibility, you generally must wait until the next annual enrollment period.

Special Enrollment Rights

If you are covered under another group health plan and involuntarily lose that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), you or your Eligible Dependents may enter the Plan under the special mid-year enrollment rights. You must request enrollment in writing within 30 days after the loss of other

coverage or the District's cessation of contributions for such other coverage. Coverage will begin on the first day of the month after the Plan receives the enrollment form.

If you acquire a new Eligible Dependent, by marriage, Domestic Partnership, birth, adoption, or placement for adoption, you have a right to enroll yourself and the new Eligible Dependent in the Plan. You must complete and submit an enrollment form within 31 days of the marriage, registration of Domestic Partnership, birth, adoption, or placement for adoption.

Additionally, pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 and effective April 1, 2009, you and your Eligible Dependents are permitted to enroll in the Plan no later than 60 days after: (i) the date you or your Eligible Dependents lose coverage under Medicaid or the State Children's Health Insurance Program ("CHIP") due to loss of eligibility; or (ii) a favorable eligibility determination is made by Medicaid or CHIP to provide you or your Eligible Dependents with premium assistance under Medicaid or CHIP.

Effective Date of Coverage

An Eligible Employee's coverage under the Plan begins on the first day of the month on or following his or her date of hire with the District.

If your application includes enrollment of Eligible Dependents, their coverage would begin on the same day that your coverage begins.

For a new Spouse of an Eligible Employee already enrolled, coverage begins on the first day of the month following marriage, but only if an application for the Spouse has been filed within 31 days of marriage.

For a new Domestic Partner of Eligible Employee already enrolled, coverage begins on the first day of the month following the date of Certified Declaration of Domestic Partnership, but only if an application for the Domestic Partner has been filed within 31 days of the Certified Declaration of Domestic Partnership.

For a newly acquired Child of an Eligible Employee already enrolled, coverage begins on the first day of the month after acquiring the Child, but only if an application for the Child is filed within 31 days of acquiring the Child.

For a Child born to an Eligible Employee who is already enrolled, coverage begins at birth, but only if an application to enroll the Child is filed within 31 days of birth.

For an adoption, coverage begins effective with the date of adoption, or when a child is legally placed for adoption, and there is the "assumption and retention" by the Eligible Employee of a legal obligation for total or partial support of such child in anticipation of the adoption of such child. An application for the Child must be filed within 31 days of adoption or placement for adoption.

Qualified Medical Child Support Orders

This Plan complies with all Qualified Medical Child Support Orders ("QMCSOs"). The QMCSO will require that the Plan cover the children even if you do not want to enroll the children in the Plan or wish to drop the children's medical coverage.

II. EXTENSION OF BENEFITS

Continuation of Coverage under FMLA and Other Laws

The Plan allows for the continuation of coverage for a leave of absence, subject to the Family and Medical Leave Act of 1993 ("FMLA"), for up to 12 weeks in a 12-month period.

The National Defense Authorization Act for Fiscal Year 2008 provides additional leave rights under certain circumstances for employees who are family members or next of kin of members in the armed forces. The Act provides for the spouse, son, daughter, or next of kin in the armed forces (including a member of the National Guard or Reserves) to take up to 26 work weeks of leave to care for the member who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious health injury or illness.

Retirees/AB528

Under AB 528 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 you retire and elect to continue coverage, you may also elect to include your Spouse/Domestic Partner but not your children. Also, if you retire or you are an active certificated employee who is contributing to STRS and is a member of STRS, your surviving Spouse/Domestic Partner may continue coverage under the Plan. Any election for continued coverage must be made within thirty-one (31) days of termination of active coverage; otherwise coverage under the Plan is forfeited. Re-enrollment is not available if coverage is dropped.

Continuation of Coverage for Military Leave

If you are called to active military duty, you and your Eligible Dependents may be eligible for coverage under TRICARE, the military service's health plan. You and your Eligible Dependents may also elect to continue benefits under this Plan if you were covered by the Plan at the time you were called to military duty.

The Plan allows for the continuation of coverage for a military leave of absence, covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Coverage may be continued until the earlier of:

- 24 months after your absence from work begins, or
- the day after the date on which you fail to timely apply for or return to employment as required by USERRA.

If you elect to continue coverage and your military service is less than 31 days, you are required to pay only your normal share of the premium for such coverage. If the length of your military service extends past 31 days, you must pay [102%] of the costs of the Plan for

similarly situated Plan participants who are not serving in military service.

If you choose not to continue coverage under the Plan during your military service, you and your Eligible Dependents are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. However, the reinstatement of coverage will be subject to any waiting periods or any limitations for Pre-Existing Conditions that would have otherwise applied had you not left for military service. In addition, as permitted by USERRA, your coverage will not include any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of military service. Any other such illness or injury will be covered by the Plan, subject to all otherwise applicable conditions and limitations of the Plan.

Note: After your USERRA continuation coverage expires, you will not thereafter receive 18 months of COBRA continuation coverage. However, if your USERRA coverage expires prior to 18 months (e.g., because you do not return to employment), you may be eligible for COBRA continuation coverage for the remainder of the original 18-month COBRA coverage period.

Continuation of Coverage under COBRA

Introduction

The San Diego & Imperial County Schools Fringe Benefits Consortium PPO Health Plan (the "Plan") complies with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (Public Law 99-272, Title X), which requires that companies continue health coverage under certain circumstances explained in this notice. If you have health coverage under the Plan, and if that coverage ends for a reason listed below, you may be able to continue your health coverage for a certain period of time. It is important that you, your covered spouse, and any covered child(ren) over the age of 18 read this notice carefully, as it outlines both your rights and your responsibilities under the law. If your coverage as an active employee under the Plan ends, please examine your options carefully before declining the continuation coverage available under COBRA. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium, or you could be denied coverage entirely.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice is intended to provide you with summary information only.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified

beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Please note that your registered domestic partner (as defined under Section 297 of the California Family Code) and his or her dependents would not be eligible to elect COBRA continuation coverage due to their status as a domestic partner or a dependent of such domestic partner (they are not "qualified beneficiaries" under federal law). However, your domestic partner and his or her dependents would be eligible for COBRA continuation coverage if such domestic partner and/or his or her dependents were covered under the Plan immediately prior to the qualifying event and you elected to cover such individual or individuals as an eligible dependent.

What is a Qualifying Event?

A qualifying event is an event that causes you or your spouse and dependent child(ren) to lose health benefits.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. For qualifying events that the District is aware of, such as the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the District, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the District must notify the Plan Administrator of the qualifying event. *However, for some qualifying events, you are required to provide notice to the District.*

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the District within 60 days after the qualifying event occurs.

What Do You Have To Do?

Once the District receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. If you wish to elect coverage, you must follow guidelines detailed in the COBRA notice. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their dependents, and parents may elect COBRA continuation coverage on behalf of their children.

If you decide to elect continued coverage, you must return your election form to the District within 60 days from the later of:

- the date your coverage would terminate due to the qualifying event; or
- the date on which the COBRA notice is initially postmarked.

You then have 45 days to pay all of the necessary retroactive and current premiums. Any medical and other expenses you incurred will *not* be covered until you return all required election forms *and* pay the applicable premiums. Your coverage will be retroactively reinstated once the premium and all required re-enrollment forms are received, and any eligible medical claims will then be processed by the Plan.

How Long Can Coverage Continue?

18 Months: If you are an *employee or the spouse or dependent child* of an employee you may elect up to 18 months of continued health coverage if you lose coverage due to the employee's:

- termination of employment (voluntary or involuntary except

for gross misconduct); or

- reduction in work hours to less than the minimum needed to remain covered by the plan.

36 Months: If you are an *employee's spouse or dependent child*, you may elect up to 36 months of continued health coverage if you lose coverage due to:

- death of the employee; or
- divorce; or
- Medicare entitlement of the employee.

If you are a *dependent child*, you may elect up to 36 months of continued health coverage if you lose coverage due to:

- no longer satisfying the dependent eligibility requirements of a plan.

Extension beyond 18 months: There are three additional circumstances when you can potentially continue COBRA coverage beyond 18 months. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

1. Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or anytime during the first 60 days of COBRA continuation coverage, and you notify the District in writing in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that the District is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event, or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event, the notice must be provided before the end of the 18-month period of COBRA continuation coverage. Your notice must include a copy of the Social Security Administration's determination. If these procedures are not followed, or the notice is not provided in writing to the District within the required 60-day period, then there will be no disability extension of COBRA continuation coverage.

2. Second Qualifying Event extension of 18-month period of continuation coverage.

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and the dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months

(including the initial period of COBRA continuation coverage).

If an employee's spouse or dependent child(ren) have a subsequent qualifying event during the initial 18 months of continuation coverage, he or she may continue coverage for up to 36 months total, from the date of the initial qualifying event. This extension is available if the employee dies, becomes entitled to Medicare, or gets divorced. The extension is also available to a dependent child who loses eligibility under the Plan as a dependent child. To obtain an extension of continuation coverage, the affected spouse or dependent child must notify the District within 60 days of the subsequent qualifying event.

In all these cases, you must make sure that the District is notified of the second qualifying event, within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree.

If these procedures are not followed, or the notice is not provided to the District within the required 60-day period, then there will be no extension of COBRA continuation coverage.

3. Medicare Extension for Spouse and Dependent Children.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and dependent children is 36 months from the date the employee became entitled to Medicare (but the covered employees maximum coverage will be 18 months).

When Does Coverage End?

Your continuation coverage will terminate on the earliest of the following dates. In no event can coverage continue beyond 36 months from the original qualifying event date.

- When no group health coverage is provided by the District for any employees; or
- When you do not pay a premium for your continued coverage within the prescribed time limit; or
- When you become covered under another group health plan. Exceptions to this rule include if the new group plan contains any exclusion or limitation with respect to any pre-existing condition that applies to you; or
- When you first become entitled to Medicare (assuming this occurs after you elect COBRA); or
- The date you or your dependent is no longer disabled if you have extended coverage for up to 29 months due to your disability, and Social Security has made a final determination that you or your dependent is no longer

disabled. (You must notify the District within 30 days of this Social Security determination).

- **The Plan does not provide an option for Individual Conversion following the expiration of COBRA benefits.**

How Much Does COBRA Coverage Cost?

You are required to pay the entire cost of your continued health coverage to the District plus a 2% administration fee. The total premium is made up of the prior employee contribution plus the employer premium paid.

Employee Contribution + <u>Employer Contribution</u> = Total Premium <u>x 2% Administration Fee</u> = COBRA Premium
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The cost of coverage during the 19th-through the 29th-month extension period for individuals who elect the Social Security disability extension may be up to 150% of the total cost.

You have 45 days from the day you elect COBRA to pay your current premium plus any retroactive premiums back to the day you lost coverage. Thereafter, you have a grace period of 30 days for regularly scheduled premium payments.

Michelle's Law

The Plan will comply with the Federal Michelle's Law. This generally means that coverage under the Plan will not be cancelled if your "qualifying dependent child" who is enrolled in the Plan (i) participates in a school-sponsored break during the school year; (ii) takes a medically necessary leave of absence from school (or takes a change in school enrollment that would otherwise result in a cancellation of coverage under the Plan) before the earlier of 12 months from the date such leave or change began or the date your "qualifying dependent child" would lose coverage under the Plan for other reasons. For this purpose, the term qualifying dependent child means your child who is a student at a post-secondary educational institution before the first day of the medical leave.

III. TERMINATION OF COVERAGE

Your coverage under the Plan is cancelled under the following conditions:

- On the date the contract between the District and the Plan is cancelled.
- On the date your premium is due after you no longer satisfy the eligibility requirements under the Plan.
- At the end of the period for which premium contribution charges have been paid when the required premium contributions for the next period has not been paid by you.
- On the next contribution due date after the Plan receives written notice of the

Employee's voluntary cancellation of coverage.

If premium contributions are paid, your coverage may continue if you were granted a temporary leave of absence up to 6 months or a sabbatical year's leave of absence up to 12 months.

Benefits terminate for early retirees and their Spouses/Domestic Partners at age 65.

There are no conversion rights under the Plan upon termination of eligibility. Review the "Continuation of Coverage under COBRA" section for COBRA benefits.

IV. BENEFITS

Determinations	<p>A Covered Expense is incurred on the date you receive the service or supply. In no event will a covered expense include:</p> <ul style="list-style-type: none">• Any charge for services of a Participating Hospital or Participating Physician in excess of the Negotiated Rate.• Any charge for services for a Non-Participating Physician or Non-Eligible Physician in excess of an Allowable Charge.• 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.• Any charge for services of a Non-Participating Hospital or Non-Participating Physician in excess of an Allowable Charge.
Deductible	<p>You and each Eligible Dependent enrolled in the Plan must meet a deductible amount for Covered Expenses incurred during any calendar year. The amount of the deductible is \$100 per individual/\$200 family maximum. Once the deductible is satisfied, no further deductible would be required for Covered Expenses incurred for the remainder of that calendar year. Additionally, Covered Expenses incurred during the last 3 months of a calendar year that would apply toward the deductible for that calendar year may be carried forward and applied to help satisfy the following calendar year's deductible.</p>
Payment for Covered Expenses	<p>This section addresses payment by the Plan for Covered Expenses exceeding the applicable deductible. No payment will be made by the Plan that exceeds the Usual, Customary and Reasonable charge.</p>

PAYMENT LEVELS

In-Network

After the calendar year deductible is met, payment is provided at 90% of the negotiated providers' contracted rate for covered expenses incurred by a member when using a Participating Hospital or Participating Physician or Provider. Once a member reaches the in-network calendar year out-of-pocket maximum, no further coinsurance will be required for the remainder of that Calendar Year.

Out-of-Network

After the calendar year deductible is met, payment is provided at 70% of

the Allowable Charge for covered expenses incurred by a member when using a Non-Participating Hospital or Non-Participating Physician or Provider. Once a member reaches the Out-of-Network Calendar Year out-of-pocket maximum, payment will be provided at 100% of the Allowable Charge for covered expenses for that member for the remainder of the Calendar Year.

Forced Providers

After the calendar year deductible is met, payment is provided at 90% of the billed charge for a covered expense when the member is unable to choose the services of a Participating Provider for the following list of providers only. This provision applies only for services rendered 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 physician when services are received in an in-network facility
- Inpatient Physician hospital visits when member is confined in an in-network facility
- Anesthesiologist when the surgeon is an in-network provider
- Radiologist and laboratories when the member has no choice of provider

Ambulance Service

After the calendar year deductible is met, payment is provided at 90% (PPO provider) or 80% (Non-PPO provider) of covered charges incurred by a member, for medically necessary surface or air ambulance transportation.

Emergency Room Facility

After the calendar year deductible is met, payment is provided at either 90% of the negotiated providers contracted rate or 70% of the Allowable charge, less the \$25 emergency room copayment. The co-payment is waived if member is admitted directly into the hospital.

Out-of-Area

After the calendar year deductible is met, payment is provided at 80% of the allowable charge for covered expenses incurred by a member outside the United States.

Maximum Benefits

LIFETIME MAXIMUM: Unlimited

CALENDAR YEAR STOP-LOSS MAXIMUM (maximum out-of-pocket)

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. This is an individual stop loss level with no family maximum.

Deductibles, dollar co-pays, non-covered expenses, prescription drug charges, mental health and substance abuse charges, and any other charges in excess of the allowable charges do not apply toward the deductible or out of pocket maximum.

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

All inpatient and outpatient Treatment of mental health and chemical dependency is carved out of the Plan and provided by the Plan's Behavioral Health Plan. Please refer to your Behavioral Health Plan Schedule of Benefits for a complete summary of benefits.

Please contact the behavioral health plan at 1 (800) 999-9585 for confidential pre-authorization and in-network referral assistance.

CHIROPRACTIC CARE/ACUPUNCTURE CARE

In-Network: After the calendar year deductible is met, payment is provided at 90% of the negotiated providers contracted rate, up to a maximum of \$50 per visit. Maximum payable is \$1,000 per calendar year.

Out-of-Network: After the calendar year deductible is met, payment is provided at 70% of the allowable charge, up to a maximum of \$50 per visit. Maximum payable is \$1,000 per calendar year.

**Benefit Reduction
Due to Pre-Existing
Condition**

All Members enrolling after the Effective Date of the Plan shall be excluded from any benefit for any conditions for which Treatment was received during the 90 days immediately preceding the Member's Effective Date. This provision also applies to newly acquired Spouses/Domestic Partners. This limitation ceases to apply to any Member after twelve (12) consecutive months of membership in the Plan. However:

- It does not apply to a Member who was covered under another district sponsored plan (through the same district) and replaced by this agreement within 31 days of that Plan's termination.
- Also, it does not apply if your child is born while you are enrolled in the Plan and you enroll this child within 31 days of his or her birth.
- It does not apply to an adopted Child who is being adopted and is enrolled within thirty (30) days of birth, adoption or placement.
- It does not apply to dependent children under the age of 19.

V. COVERED EXPENSES

Hospital

Covered Services

- Inpatient services and supplies provided by a Hospital, except private room charges over the prevailing two-bed room rate of the Hospital.
- Outpatient services and supplies provided by a Hospital, including those in connection with surgery performed at a licensed outpatient surgical center.
- Services provided by a licensed outpatient/ambulatory surgical center in 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 applicable legal and regulatory requirements of an outpatient surgical center

providing surgical services.

Conditions of Service

- Services must be those that are regularly provided and billed by a Hospital.

Benefits are provided only for the minimum number of days required to treat the Member's illness, injury, or condition.

Psychiatric Health Facility

Please refer to the section entitled "Mental or Nervous Disorder and Substance Abuse".

Skilled Nursing Facility

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.

Conditions of Service

- The Member must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- 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.
- 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.

Admission to a Skilled Nursing Facility for non-skilled or custodial care is excluded.

Home Health Care

Covered Services

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, covered occupational therapy, or covered speech therapy.
- Services of a medical social service worker.
- 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 the above first two points.
- Necessary covered medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Custodial care is excluded.

Conditions of Service

- 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.
- Services must be provided and billed by the Home Health Agency or Visiting Nurse Association.

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 one hundred (100) visits per calendar year. (A visit is a shift of eight (8) hours or less.)

Professional Services

- Services of a Physician or Physician Assistant as defined in another portion of the Plan.
- Services of an Anesthetist.
- Services of a midwife who is also a Licensed Registered Nurse acting within the scope of his/her license.
- Services of a Licensed Physical Therapist.
- Services of a Certified Registered Nurse Anesthetist.
- Services of a Registered Nurse.
- Services of a Licensed Vocational Nurse.
- Services of a Nurse Practitioner.
- Services of a Clinical Laboratory.
- Services of a Skilled Nursing Facility.
- Services of a Home Health Agency or Visiting Nurse Association.
- Services of a Licensed Ambulance Company.
- Services of a licensed retail pharmacy

Additional Services and Supplies

- Following ambulance services:
 - 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.
 - 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.
 - 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.

- Outpatient diagnostic radiology and laboratory services for Treatment of an illness or injury. Multiple non-Emergency laboratory tests will be paid as Automated Multi-channel Tests.
- Radiation therapy, chemotherapy, hemodialysis, and other such FDA approved, Physician ordered, non-Investigational or Experimental Treatment appropriate for the diagnosed illness or injury.
- Surgical implants, except devices used in non covered cosmetic procedures.
- Orthotic and Prosthetic devices, such as 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 device. This includes initial orthotic or prosthetic device and repair or replacement of existing devices when Medically Necessary.
- The first pair of contact lenses and the first pair of eyeglasses when required as a result of Medically Necessary eye surgery.
- 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: (i) ordered by a Physician; (ii) of no further use when medical need ends; (iii) usable only by the patient; (iv) not primarily for the Member's comfort or hygiene; (v) not for environmental control; (vi) not for exercise; and (vii) 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.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
- 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 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 lymphedema, is covered. Additionally, screening procedures as recommended by the Member's Physician are covered. (In accordance with the Women's Health and Cancer Act.)

- Papanicolaou test (Pap Smear) for all females as recommended by the Member's Physician.
- Hospice Care Services provided in an inpatient Hospice facility or Member's home when an Attending Physician certifies that the patient is terminally ill with a life expectancy of six (6) months or less. Hospice Care Services are subject to Utilization Review every sixty (60) days. Covered Hospice Care expenses include: (i) room and board charged by the Hospice; (ii) other Covered Services and Supplies; (iii) part-time nursing care by or supervised by a registered graduate nurse (R.N., L.V.N., or L.P.N.); (iv) home Health Care Services provided by a Home Hospice Agency; (v) counseling for the Member and the Member's eligible dependents as provided through the outpatient provisions relating to Mental and Nervous Disorders; and (vi) custodial care is excluded.
- Outpatient surgical supplies used in conjunction with eligible outpatient surgery; such supplies are subject to the Usual, Customary, and Reasonable amounts.

Dental Care

Admission for Dental Care

- *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.).
- *Conditions of Service.* 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. Hospital stays for the purpose of administering general anesthesia are not a covered expense.

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 the Plan. **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. For purposes of this paragraph, Accidental Injury shall mean a physical harm or disability to the body caused by a specific unexpected external means that does not arise out of or in the course of employment. The physical harm or disability must have occurred at an identifiable time and place. All Accidental Injuries sustained in connection with one accident are considered to be one Accidental Injury. The term Accidental Injury does not include

illness, disease or infection, except pyogenic infection occurring through an accidental cut or wound.

Pregnancy and Maternity Care

- All Comprehensive Benefits when provided for pregnancy and maternity care, including the California Department of Health Services expanded Alpha Feta Protein (AFP) Testing Program (surrogate pregnancies are not covered)+.
- In accordance with the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a cesarean section. When delivery occurs outside the Hospital, the minimum stay begins when the mother or newborn is admitted. 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 or both earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable), provided that the mother agrees to the discharge.
- 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 thirty-one (31) days of birth and any additional premiums, if any, are paid.
- Termination of pregnancy.

Family Planning

- Limited to one consultation per Member while eligible under the Plan.

Organ and Tissue Transplants

Human organ and tissue transplant benefits are provided according to the terms and conditions set forth in a separate Organ and Tissue Transplant Policy (Transplant Policy) that has been issued to the Plan. Transplant-related benefits will be provided to each covered person during the transplant benefit period specified in the Transplant Policy. Once the transplant benefit period has elapsed, all transplant-related benefits will revert back to the Plan, subject to its terms and conditions. Transplant related benefits are only available to individuals that:

- are eligible for medical benefits under the Plan;
- meet all the terms and conditions outlined in the Transplant Policy; and
- have fulfilled the Pre-Existing Condition waiting period (if applicable) as defined in the Transplant Policy.
- Covered persons that are subject to a Pre-Existing Condition waiting period under the Transplant Policy will receive transplant benefits according to the terms and conditions of the Plan until the Pre-Existing Condition waiting period has elapsed.

Mental or Nervous Disorders and

All inpatient and outpatient Treatment of mental health and chemical dependency is carved out of the Plan and provided by a behavioral

Substance Abuse

health plan. Please refer to your Behavioral Health Plan Schedule of Benefits for a summary of coverage.

- INPATIENT PLAN DESIGN – **The Behavioral Health Plan participating provider only.** No inpatient deductible, co-payment, or lifetime maximum. Severe Mental Illness (SMI) has no maximum; all other diagnosis is limited to thirty (30) days annually (combined with Chemical Dependency). Chemical Dependency Treatment is limited to two (2) in a lifetime. **Pre-authorization through the Behavioral Health Plan is required.**
- Outpatient Plan Design – In-network/out-of-network benefits. In-network services fifty-two (52) office visits per calendar year; SMI is unlimited In-network services \$10 co-payment per office visit. Out-of-Network services maximum twenty (20) office visits per year. Out-of-Network services – the Behavioral Health Plan will pay \$50 maximum per office visit.

In-Network benefits require pre-authorization. Please contact the Behavioral Health Plan at (800) 999-9585 for confidential pre-authorization and in-network referral assistance.

Preventative Care

Benefits are provided for routine physician examinations, laboratory and radiology services provided to a Member in accordance with the guidelines established and recommended by the American Medical Association or American Pediatric Society. Benefits for these services are limited to a maximum of \$200 per Member in a calendar year.

Pap smear and Mammography as part of a well woman exam are covered and are not subject to the \$200 calendar year maximum.

Immunizations provided to a Member who is a dependent child are covered and are not subject to the \$200 calendar year maximum.

Christian Science Benefits

Nurse. Benefits will be provided for personal care and attendance of a Christian Science Nurse authorized by the Mother Church and who are not your family members or family members of your Eligible Dependent.

- \$4.00 maximum per hour
- 1 maximum visit per day
- 5 maximum hours per visit
- 70 maximum visits per calendar year

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

- \$10.00 maximum per visit
- 1 maximum visit per day
- 70 maximum visits per calendar year

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.

VI. PRESCRIPTION DRUG BENEFITS

Payment

An expense is incurred on the date you or your Eligible Dependent receives the drug for which the charge is made.

When you or your Eligible Dependent present your 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 pharmacy benefits manager), you or your Eligible Dependent pays a co-pay or coinsurance in the amount of \$5.00 co-payment for generic, \$10.00 co-payment for brand. The amount of medication supplied for each prescription at a walk-in pharmacy is the amount prescribed, up to a maximum of a 30-day supply.

Through mail-order a 90-day supply of a maintenance prescription is available with a \$5.00 co-payment for generic or brand. Any Member with a maintenance medication must use the Express Scripts Exclusive Home Delivery Program.

When the Member does not present his or her medical identification card or goes to a non-participating pharmacy, payment is provided to the Member for the reasonable charge for covered expense incurred, less any copay/deductible as outlined in the "Benefit Highlights". The reasonable charge is determined by the Plan. This benefit is payable only if the Member files a properly completed Claim form within ninety (90) days of the date of purchase, but never later than 365 days of the date of purchase.

Condition of Service

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

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

Prescription Drug Exclusions and Limitations

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

- Medicines not requiring a prescription, except insulin.
- Contraceptive medications (with the exception of oral contraceptives), materials or devices.
- Vitamins regardless of whether Medically Necessary. (Unless the vitamin is the only known Treatment for the Illness or Injury.)
- Tretinoin, all forms (e.g., Retin-A, Renova) or any other acne

medication for you or your Eligible Dependents over 25 years of age, unless a Physician certifies that the drug is for a Medically Necessary reason.

- Charges for administration of any drug.
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use. (Except 2 pairs of medical support hose per year for a diagnosed peripheral vascular disorder.)
- Prescriptions that you or your Eligible Dependents are entitled to receive without charge from any Workers' Compensation laws.
- Medication taken or administered while in a Hospital, extended care facility, nursing home, or similar institution (these charges are paid by the Plan).
- Any prescription filled in excess of the number specified by the Physician or any refill dispensed after 1 year from the original fill date.
- Dietary supplements, health aids, or drugs for the purpose of birth control unless otherwise specified.
- Anorectic (drugs used for weight control).
- Nicorette (or any other drug for which the intended use is to deter smoking).
- Infertility medications.
- Yocon (Yohimbine).
- Any prescription drug for Treatment of a benefit excluded by the Plan.
- 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.
- Any drug which the Food and Drug Administration has not approved for general use.
- Any drugs dispensed by a Physician, dentist, or podiatrist.
- Rogaine, Minoxidil, or any other product to promote hair growth regardless of the reason for the hair loss.
- Immunization agents, biological sera, blood or plasma.

The prescription drug coverage provided through the Plan is on average at least as good as standard Medicare prescription drug coverage and provides Creditable Coverage under Medicare Part D guidelines.

VII. EXCLUSIONS AND LIMITATIONS

Benefits under the Plan are not provided for or in connection with the following, which is not meant to be an all-inclusive list of exclusions and limitations:

- Services or supplies that are not Medically Necessary. 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 Expenses, Treatment, or therapy are also excluded. 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.
- Services received before you or your Eligible Dependent are enrolled in the Plan or during an inpatient stay that began before such date. Services received after you or your Eligible Dependent's coverage ends, except as specifically stated under the section entitled "**EXTENSION OF BENEFITS**".
- Any charge of a Participating Hospital or Participating Physician in excess of the Negotiated Rate.
- Any charge of a Non-Participating Physician or Non-Eligible Physician in excess of the Allowable Charge.
- Any charge of a Non-Participating Hospital or related health provider in excess of Allowable Charges.
- Services not specifically listed in the Plan as covered services.
- Services for which you or your Eligible Dependent are not legally obligated to pay. Services for which no charge is made to you or your Eligible Dependent. Services for which no charge is made to you or your Eligible Dependent in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines.
 - It must be internationally known as being devoted mainly to medical research.
 - At least ten percent of its yearly budget must be spent on research not directly related to patient care.
 - At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care.
 - It must accept patients who are unable to pay.
 - Two-thirds of its patients must have conditions directly related to the Hospital's research.
- Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any workers' compensation, employer's liability law, or occupational disease law, even if you or your Eligible Dependent does not claim those benefits.
- 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.
- 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.

- Professional services received from a person who lives in your home or who is related to you or your Eligible Dependent by blood or marriage or is otherwise a family member.
- 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.
- 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.
- 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 the Plan.
- 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. Braces, other orthodontic appliances, or orthodontic services, including surgery to correct malocclusion.
- Hearing aids and/or routine hearing tests.
- 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, Lasik, or any other procedure to treat a refractive error of the eye, such as nearsightedness (myopia) and/or astigmatism. Any procedure to treat farsightedness.
- 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.
- Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.
- Cosmetic and Reconstructive Surgery, etc. Any surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal, but which may be considered unpleasing or unsightly, except for:
 - Surgery to correct deformities that result from a sickness, congenital defects that interfere with bodily, but not psychological function, and congenital defects of a newborn Child.
 - Coverage required by the Women's Health and Cancer Rights Act (*i.e.*, reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including

lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient.

- Services primarily for weight control or Treatment of obesity. This exclusion will not apply to surgical Treatment of obesity if:
 - Surgical Treatment of obesity is necessary to treat another life-threatening condition involving obesity.
 - It has been documented that non-surgical Treatments of the life threatening obesity have failed.
- 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.
- Sterilization, sterilization reversal, artificial insemination and in vitro fertilization or any other medical, surgical, or pharmaceutical intervention intended to bring about pregnancy, unless otherwise specifically stated as a covered expense.
- Surrogate pregnancies.
- Birth control devices or medication, except oral contraceptives.
- Orthopedic shoes (except when joined to braces) or shoe inserts, orthotics. 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.
- 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.
- Services or supplies for the Treatment of an illness, disease, or injury causing the Member to be Totally Disabled, if:
 - Coverage under the Plan becomes effective within sixty (60) days after the termination of a prior carrier's plan.
 - The Member was Totally Disabled on the date that the prior carrier's plan terminated.
 - The Member is entitled to an extension of benefits in accordance with the California Health and Safety Code and the California Insurance Code or to any similar extension of coverage for the totally disabling condition.
- Benefits provided by another health benefit plan will have benefits applied in accordance with the section entitled "**Coordination of Benefits**".
- Expenses for screening and testing of potential organ or tissue donor, except as specified under "**COVERED EXPENSES**".
- Educational services.
- Nutritional counseling or food supplements regardless of the illness, injury, or necessity of such services.
- Telephone consultations.
- Any injury or illness directly or indirectly caused by suicide or intentionally self-inflicted injuries or illnesses, whether sane or insane, or any injury sustained in the act of

committing a felony. The term "self-inflicted injuries or illnesses" shall include any injury sustained where voluntary consumption of alcohol, an illegal substance, a drug prescribed for someone other than the user, or excessive amounts of a prescription or over-the-counter drug is a contributing factor to the injury. For purposes of this subsection, if it is determined by the Plan that an error was made in the payment of a claim, the Plan reserves the right to request overpayment of the claim(s) pursuant to California Health & Safety Code Section 1371.1. The Plan also reserves the right to seek reimbursement for the payment of claim(s) from a third party or other sources, including from any insurance proceeds, settlement amounts, or amounts recovered in a lawsuit.

- Custodial care is excluded, regardless of who prescribes or renders such care.
- 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.
- Services not prescribed by a licensed Physician as defined elsewhere in the Plan.
- Laetrile is excluded.
- 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.
- Charges for unkept appointments, completion of Claim forms or providing supplementary information, or interviews in which the patient is not seen.
- Post-surgical Treatment during the postoperative follow-up period when such follow-up is normally considered part of the surgical Treatment.
- Duplicate durable medical equipment and repair or replacement of damaged, lost, or stolen durable medical equipment.
- Travel expenses, except as otherwise specified.
- Services payable by reason of any false statement.
- 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.
- Marriage, family, career, pastoral, or financial counseling.
- Residents or interns of a Hospital.
- Drugs dispensed by a Physician, dentist or podiatrist.
- Charges for photographs, photocopying, and/or videos.
- Exercise programs or exercise equipment regardless of Medical Necessity.
- 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, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene, or beautification, etc.).

VIII. UTILIZATION MANAGEMENT

Background Benefits under the Plan are provided only for Medically Necessary services. Utilization management provides you and your Eligible

Dependents 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, you or your Eligible Dependents will know in advance whether the services are Medically Necessary and therefore eligible for benefits.

**Preauthorization
Review
Requirement**

Utilization review is required for all non-emergency, inpatient hospital stays. **Please call (800) 262-4242 for assistance.**

NON-COMPLIANCE SUBJECTS BENEFITS TO AN ADDITIONAL \$300 DEDUCTIBLE

If the hospital admission is not authorized, it is because the utilization review organization feels that services are not Medically Necessary by their standards.

Participating Physicians should initiate this process for you; however, it is your responsibility to make sure the pre-authorization is completed. If the procedure is due to an urgent or emergency condition, you or the hospital must contact the utilization review organization within 48 hours.

Non-Participating Physicians may not be aware of your pre-authorization requirement. Therefore, you must remind your physician to contact the local utilization review organization before the services are scheduled.

**How to Obtain Pre-
Authorization**

Physicians should initiate the pre-authorization review process by calling the utilization review organization at (800) 262-4242. If you or your Eligible Dependent does not receive the certified service within 20 days of the pre-authorization, or if the nature of the service changes, a new pre-service review must be obtained.

If the review agency determines that the proposed services are Medically Necessary, they will certify those services for the period of time that is medically appropriate. If the review agency determines that the services are not Medically Necessary, your Physician will be notified immediately. Written notice then will be sent to you, your Physician and the provider of the service.

If pre-service review was not required or performed as required, or if the services you receive exceed the originally certified period, the services are subject to concurrent review and retrospective review.

**Admission and
Concurrent Review**

Admissions to Participating Hospitals that cannot be scheduled in advance, such as emergencies, are evaluated when you are admitted to be certain that the admission is Medically Necessary by utilization standards. To help keep down the cost of hospital care, all admissions to hospitals will be reviewed during your stay to determine whether continued hospitalization is Medically Necessary.

**Claims
(Retrospective)
Review**

Claims for all admissions to Non-Participating Hospitals and those admissions to Participating Hospitals that are not certified as Medically Necessary will be reviewed to determine whether all or part of the stay will be covered. If it is determined that the services were not Medically Necessary, they will be retrospectively denied certification.

IT IS ALWAYS YOUR RESPONSIBILITY TO CONFIRM THAT THE REVIEW HAS BEEN PERFORMED.

How Utilization Review Affects Benefit Payments

In order for the full benefits of the Plan to be payable to you, the following criteria must be satisfied:

- The appropriate utilization reviews must be performed. When pre-authorization review is not performed as required for a Hospital admission, you or your Eligible Dependent will be applied an additional \$300 deductible per admission.
- The services must be Medically Necessary. Inpatient hospital benefits will be provided only when an inpatient stay is Medically Necessary. If you proceed with inpatient services that have been determined to be not Medically Necessary at any stage of the review process, benefits under the Plan will not be provided for those services.

Services that are not reviewed through the applicable utilization reviews will be reviewed when the bill is submitted for 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.

Disagreements with Utilization Management Determinations

If you or your Physician disagrees with the Plan's utilization management determination or question how it was reached, you may request a reconsideration. Requests for reconsideration must be directed, in writing, to the review agency that made the review determination. Written requests must include medical information that supports the Medical Necessity of the services.

If you do not receive a response to the request for reconsideration within 60 days, it is automatically deemed to be denied.

If the reconsideration decision is not satisfactory, a request for an appeal of the reconsidered decision may be submitted, in writing, to the Plan Administrator.

In the event that the appeal decision is still unsatisfactory, the remedy is BINDING ARBITRATION or small claims action.

Personal Case Management Program

The Personal Case Management Program allows you and your Eligible Dependents to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care.

The Plan will determine when personal case management will be offered. If the Plan determines that you or your Eligible Dependent's needs could be met more efficiently, an alternate treatment plan may be recommended. This may include providing benefits not otherwise specifically covered under the Plan. The Plan provides these services at its sole discretion. You and your Eligible Dependents do not have a right to request personal case management.

The Plan makes treatment recommendations only; any decisions regarding you or your Eligible Dependent's treatment belong to you and your Physician. The Plan will in no way prejudice or compromise your freedom to make such decisions.

IX. COORDINATION OF BENEFITS

General

Coordination of Benefits ("COB") is a feature of the Plan that prevents duplicate payment of covered charges if a Plan participant is covered under more than one benefits program. In order to ensure that you receive the maximum benefits if you have duplicate coverage, always present both ID cards and take the claim forms (if required) from both benefit programs when you receive service.

COB determines which benefit plan is the primary payer (which plan pays first) and specifies how much is paid.

Determining the Primary Payer

Several rules are used to determine which benefit plan is the primary payer (or primary carrier) if a person is covered by more than one plan. The rules for primary payer are applied in the following order:

- A group benefits plan that does not have a COB feature is always the primary payer.
- In the event of a motor vehicle accident, the Plan is not primary. The other plan may include, but not be limited to, auto medical insurance coverage, no-fault coverage, casualty coverage or liability insurance.
- A benefits plan that covers the patient as an employee is the primary payer and pays before a plan that covers the patient as a dependent.
- A benefits plan that covers the patient as an active employee is the primary payer and pays before a plan that covers the patient as an inactive employee or retiree.
- If a child is covered under both parents' plans, the plan covering the parent whose birthday occurs earlier in the year pays before the plan covering the other parent.
- If the child's parents are divorced, separated, or not married, the primary payer is determined in the following order:
 - The plan of the parent who by court order or agency ruling is responsible for the child's health care expenses is the primary payer.
 - If there is no decree or agency ruling, the plan that covers the child as a dependent of the custodial parent is the primary payer. The plan of the non-custodial parent is secondary.
 - If there is no decree or agency ruling, the custodial parent's plan is the primary payer, and if the custodial parent remarries, the plan of the custodial parent's Spouse is secondary. The plan of the non-custodial parent is tertiary.
 - If the parents have joint custody of the child, the plan covering the parent whose birthday occurs earlier in the year pays before the plan covering the other parent.
 - For purposes of this COB, if there is no decree or agency ruling, "custody" will be determined based upon which parent

may claim the child as an IRS dependent.

- Services Provided Through The HMO Provider Network or Facility. Coordination of Benefit provisions of the 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 the Plan allow that service or supply. All such Claims must be submitted to the 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 the Plan.
- If none of the above rules establish the order of payment, the plan covering the participant for the longer period of time pays before the plan covering the plan participant for the shorter period of time.

The following may help you understand how COB works when this Plan is secondary. As a secondary payer, this Plan pays benefits after your primary plan has paid. This Plan will never pay more as the secondary plan than it would have paid if it had been the primary plan.

With COB, this Plan's benefits are paid up to this Plan's benefit level. When you submit a claim for a charge that this Plan covers at 80%, and this Plan is determined to be the secondary carrier, this Plan pays 80% of the covered benefit less any amount the primary plan or carrier paid.

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 the Plan.

Coordination of Benefits and Medicare

Active Employees

Medicare coverage is secondary to the Plan for an active employee, age 65 or over, and a spouse, age 65 or over, of such active employee. Medicare is also secondary for any disabled covered dependents, except in the case for End-stage Renal Failure Disease where Medicare becomes primary after 36 months of the disease. Medicare coverage, even on a secondary basis, can provide valuable benefits. If you apply when eligible for Medicare Part A, there is no premium charge.

In any situation where this Plan would have been secondary to Medicare had the Plan participant enrolled, this Plan will not pay for any expenses

that otherwise would have been paid under Medicare Parts A and/or B, regardless of whether or not the Plan participant actually enrolled.

Note: For active employees, age 65 or over, and their spouses, age 65 or over, federal law requires that Medicare be a secondary payer and pay after an employer-sponsored medical plan, under which these active employees and spouses are covered. However, an active employee, age 65 or over, has the option of rejecting the employer-sponsored medical plan with the result that Medicare becomes the primary payer. Rejection of this employer-sponsored medical plan should be submitted, in writing, to the District.

Retired Employees

For retired employees and their spouses, age 65 or over, federal law requires that Medicare be the primary payer. This means that this Plan is a secondary payer and pays up to the benefit level of this Plan. If you do not apply when eligible for Medicare, this Plan will not pay for any expenses that otherwise would have been paid under Medicare Parts A and/or B, had you enrolled.

Medicare and Limiting Charges

When Medicare is the primary or secondary payer for a Plan participant, the Plan specifically limits coverage of Medicare balance bills to the limiting charge amounts. The limiting charge means the Medicare-approved amount for those entities or individuals providing services that are neither a Participating Hospital nor a Participating Physician.

Right of Recovery

Whenever the Plan pays health care benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Plan participant on whose behalf such payment was made.

If a covered Member receives any recovery by way of judgment, 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).

A Plan participant, health care service provider, another health benefit plan, an insurer, or any other person or entity who receives a payment for health care expenses exceeding the amount of benefits payable under the terms of the Plan, or on whose behalf such payment was made, must return the amount of such erroneous payment to the Plan within 30 days of discover or demand. The Plan Administrator will have no obligation to secure payment for the health care expense for which the erroneous payment was made or to which it was applied.

X. SUBROGATION

General

The Plan reserves all rights of subrogation. This means that the Plan has the right to recover its previously paid benefit payments from any award, settlement, or damages that you or your covered dependents may receive or to which you may become entitled. It also means that

the Plan has the right to assert your rights (take action on your behalf) to obtain an award, settlement, or damages. The most common situations involving subrogation are auto accidents, but others include medical malpractice, accidental injuries, negligence, defective products, etc.

Note: You must immediately notify the Plan Administrator whenever an injury or illness arises as a result of an accident, a person's negligence, or any other circumstances that may entitle you or your covered dependent to an award, settlement or damages.

Liens

The Plan will have the first lien to the extent of any benefits advanced, upon all awards, settlements or damages. This lien will be in the amount of benefits provided or the amount of benefits that will be provided under the Plan, plus the reasonable expenses, including attorneys' fees, to enforce the Plan's rights.

The Member agrees to advise the Plan in writing within sixty (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 the Plan. 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 the Plan and will result in the Member being personally responsible for reimbursing the Plan.

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. This right to recover includes the Plan's ability to assert rights on the Member's behalf to obtain an award, settlement or damages.

If a covered Member receives any recovery by way of judgment, 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).

XI. APPEAL RIGHTS

The Plan provides that treatment or services must be Medically Necessary and be covered by your 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 Plan Administrator has the responsibility for determining whether claims are payable. The Plan's Peer Review Committee must agree if the denial is based on lack of Medical Necessity.

Action by the Plan, including any denial, and reasons for denial, will be given in writing within

90 days after the Plan Administrator receives the claim (though the period will be extended if you were notified that additional time was needed to make a decision).

Appeal Procedure

If a Member does not agree, either the employee Member or the employee Member's attending Physician, at the request of the employee Member, 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 employee Member and/or the Physician are entitled to review all documents pertinent to the denial of the claim.

If the Plan Administrator 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 Plan Administrator has expired.

XII. GENERAL PROVISIONS

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 employee Member must initiate and file arbitration in accordance with California law and in compliance with the rules established by JAMS (Judicial Arbitration Mediation Services). This request for arbitration must be in writing to the Plan Administrator. The applicant is responsible for the administrative filing fee as established by JAMS. 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, California 92111-7399

Under the Plan the employee Member has substituted his/her right to trial by court or jury with binding arbitration as to the dispute.

Notices Any notice required to be made to the Plan must be mailed to the following address:

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

Protected Health Information The Plan Administrator and/or his or her designee is the custodian of records of the Plan. Any private health information of a Member will be protected by the custodian of records of the Plan. The protections apply where the information is transmitted or maintained electronically, on paper or verbally. Any private health information is restricted to use in the Plan administration functions. The Plan will use and disclose private 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.

Independent Contractor

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.

Expense in Excess of Benefits

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

Receipt of Claims

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 12 months from the date services were 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: cancelled checks, receipts or balance due statements are not acceptable. All claims must be filed in English, in U.S. currency and mailed to the following address:

San Diego and Imperial County Schools
Fringe Benefits Consortium
PO Box 211578
Eagan MN 55121

Notice of Privacy Practices

The Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to this information. This notice shall also inform you of whom you may contact in the event of questions, or if you would like to receive an accounting of all disclosures of your protected health information. **The following is only a brief outline; to review the complete document please see the section below entitled "WHERE TO GO TO GET COPIES OF OUR CURRENT PRIVACY NOTICE."**

Your employer, Palomar Community College, sponsors and maintains a group health plan, San Diego and Imperial County Schools Fringe Benefits Consortium (the "Plan") for the benefit of its employees and their eligible dependents. This notice defines the privacy practices of the Plan as it relates to employees, covered dependents, and if applicable, retirees. This notice describes how the Plan may use and disclose protected health information ("PHI") to carry out treatment, payment, or health care operations, and for other purposes as permitted or required by law.

The Plan understands that your medical information, and that of your dependents, is personal. The Plan is committed to protecting this information. The Plan is required by law to maintain the privacy of its PHI. The Plan has appointed a privacy officer, and each member of

the privacy implementation team has been properly trained to perform his or her work functions. On occasion, the Plan may be in possession of your PHI. The Plan is required by law to make sure that your medical information is kept private, when obtained, and to give you notice of our legal duties and privacy practices. The Plan is required to abide by the terms of this Notice of Privacy Practices as necessary and to make the Notice effective for all PHI maintained by the Plan. If the Plan makes material changes to its privacy practices, copies of revised notices will be mailed to all participants and posted in the workplace.

WHERE TO GO TO GET COPIES OF OUR CURRENT PRIVACY NOTICE:

San Diego and Imperial County Schools
Fringe Benefits Consortium
6401 Linda Vista Road, #505
San Diego, CA 92111-7399
(858) 569.5347

<http://www.sdcoe.k12.ca.us/business2/?loc=risk-fbc&m=4&pi=risk>

Contact: Fringe Benefits Consortium, Privacy Officer

HIPAA Exemptions

The law allows for self-funded government plans to be exempt from all or part of HIPAA portability. The federal law requires notification of the provisions for which the plan has elected exemption. The 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.

XIII. AMENDMENT OR TERMINATION OF THE PLAN

Although the District expects to maintain the Plan indefinitely, it is not legally required to do so, and it reserves the right, as Plan Sponsor, to amend or terminate the Plan at any time and without liability. No provision of the Plan or any of its related documents shall create any vested rights in any employee, participant, or other person. The Plan may be amended or terminated by a written instrument duly adopted by the District or any of its delegates.

XIV. IMPORTANT DEFINITIONS

Words you find that are capitalized within the Booklet are defined in this section of the Booklet. The presence of the following definitions is not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Booklet for that information.

Allowable Charge "Allowable Charge" means as determined annually by the Plan, a charge which falls within the common range of fees billed by a majority of Physicians for a procedure that is justified based on the complexity or the severity of Treatment for a specific case.

Calendar Year	“Calendar Year” means the twelve (12) month period starting each January 1 at 12:01 a.m. Pacific Standard Time, and ending at 12:01 a.m. on the next succeeding year, Pacific Standard Time.
Custodial Care	“Custodial Care” means 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.
District	"District" means Palomar Community College.
Domestic Partner	“Domestic Partner” or "Domestic Partnership" means two adults who have received a Certificate of Registration of Domestic Partnership from the Secretary of State of California. Domestic Partner status shall last only until the earlier of: (i) termination of the domestic partnership pursuant to an order of the California Superior Court, or (ii) the expiration of 6 months following the date a Notice of Termination of Domestic Partnership was filed with the Secretary of State of California.
Eligible Dependents	<p>"Eligible Dependents" means:</p> <ul style="list-style-type: none"> • The Employee's Spouse. • The Employee's Domestic Partner. • The Employee's children who are under 26 years of age and not eligible for another employer’s health plan. For these purposes the term “children” shall mean: (i) biological children of the Employee; and (ii) children of a Domestic Partner and stepchildren of the Employee, but only to the extent such child or children meet, from the perspective of the Employee, the dependency ruling by the IRS as found in Section 105 of the Internal Revenue Code and the Treasury regulations thereunder. • A child who is adopted (or legally placed child pending adoption) by the Employee. Placed for adoption means there is the assumption and retention by the Employee of a legal obligation for total or partial support of such Child in anticipation of the adoption of such Child. • A child to which the Employee has been appointed legal guardian and when the Child lives with and depends on the Employee for care and support (as determined by the applicable District in its sole and absolute discretion). • A child for whom the Employee or Spouse is required to provide coverage due to a Medical Child Support Order (MCSO). • An unmarried child enrolled prior to age 26 who, upon reaching age 26, is dependent upon the Employee for support and is incapable of self-sustaining employment due to a mental or

physical impairment/disability that was incurred prior to reaching age 26. For purposes of this paragraph, disability shall mean the dependent child'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 twelve (12) months or end in death. If, because of a medical condition, the dependent child cannot do the work that he/she 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 dependent child can perform other duties, even if such duties involve different skills or the compensation is less than that of the previous work, such dependent child cannot be considered disabled. (The Plan has modeled this provision on the Social Security Administration's definition of "Disability".) A Physician must certify any such disability, and such written certification must be received by the Plan within thirty-one (31) days of the date the dependent child reaches the maximum age. Two (2) years after the dependent child's 27th birthday, the Plan may request proof of continuing dependency and disability, but not more often than once a year.

Emergency

"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 (i) permanently placing the Member's health or life in jeopardy, (ii) causing other serious medical consequences, (iii) causing serious impairment to bodily functions, or (iv) causing serious and permanent dysfunction of any body organ or part. Whether a medical condition constitutes an Emergency is based solely on the Plan Administrator's or its agents' review of the emergency room report, subject to its complete discretion, and shall be based on the age of the patient, the time of day, the presenting symptoms and the patient's medical history.

Hospital

"Hospital" means a facility that provides on-premise diagnosis, Treatment, and care of persons who need acute hospital care under the supervision of Physicians. To constitute a Hospital, it must (i) be licensed as a general acute care hospital according to state and local laws, (ii) be registered as a general hospital by the American Hospital Association, and (iii) meet accreditation standards set by the Joint Commission on Accreditation of Hospitals (this standard applies to hospitals within the United States only).

Medically Necessary

"Medically Necessary" means care and Treatment that is recommended or approved by a Physician, is consistent with the patient's condition or accepted standards of good medical practice, is medically proven to be effective Treatment of the condition, is not performed mainly for the convenience of the patient or provider of medical services, is not conducted for research purposes, and is the most appropriate level of services which can be safely provided to the patient (as determined or approved by the Plan's medical review process). All of these criteria must be met; merely because a Physician

recommends or approves certain care does not mean that it is Medically Necessary.

Member	"Member" means the Employee and Eligible Dependents who are covered by the terms of the Plan pursuant to satisfying and continuing to maintain eligibility status and being properly enrolled in the Plan.
Mental or Nervous Disorders	"Mental or Nervous Disorders" means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of <i>International Classification of Diseases</i> , published by the U.S. Department of Health and Human Services, or is listed in the current edition of <i>Diagnostic and Statistical Manual of Mental Disorders</i> , published by the American Psychiatric Association.
Negotiated Rate	"Negotiated Rate" means the fee Participating Hospitals and Participating Physicians agree to accept as payment in full for Covered Expenses under the Plan.
Non-Eligible Physician	"Non-Eligible Physician" means a Physician who is of a specialty with which the Plan or its agents do not currently enter into Participating Agreements.
Non-Participating Hospital	"Non-Participating Hospital" means a Hospital that does not have a participating agreement with the Plan or its agents in effect at the time services are rendered.
Non-Participating Physician	"Non-Participating Physician" means 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.
Out-of-Area Services	"Out-of-Area Services" means all covered services incurred outside of the United States of America.
Participating Hospital	"Participating Hospital" means a Hospital that has a Participating Agreement in effect with the Plan or its agents at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full for covered services (excepting applicable co-insurance and co-pays per District benefit levels). Participating Hospitals agree to participate in the 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.
Participating Physician	"Participating Physician" means 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 (excepting applicable co-insurance and co-pays per District benefit levels).

Physician	<p>"Physician" means 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 who is duly licensed to prescribe and administer drugs and to perform surgery within the scope of his/her license. Additionally, the term Physician shall include 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 the Plan document, and when benefits would be payable if the services were provided by a Physician as defined in the first sentence of this Section 1.28 of the Plan: (i) a dentist (D.D.S.), (ii) an optometrist (O.D.), (iii) a dispensing optician, (iv) a podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.), (v) a psychologist, (vi) a chiropractor (D.C.), (vii) an acupuncturist (but only for acupuncture and for no other services), (viii) a clinical social worker (C.S.W. or L.C.S.W.), (ix) a marriage, family and child counselor (M.F.C.C.), (x) a physical therapist (P.T. or R.P.T.), (xi) a speech pathologist, (xii) an audiologist, (xiii) an occupational therapist (O.R.T.), and (xiv) a Physician assistant (P.A).</p>
Plan	<p>"Plan" means the San Diego and Imperial County Schools/Fringe Benefits Consortium Custom Health Benefits Plan, a formal written document describing the benefits and the provisions under which such benefits will be paid to covered Members, including any exhibits attached hereto. The Plan became effective July 1, 2009.</p>
Plan Administrator	<p>"Plan Administrator" means the San Diego and Imperial County Schools/Fringe Benefits Consortium, the authorized agent to which is the San Diego County Superintendent of Schools Risk Management Department. Pursuant to an agreement originally effective July 1, 1994, as later amended, the Plan Administrator has assumed all obligations, assets, claims, responsibilities and authority of the San Diego County Schools Risk Management Joint Powers Authority Self-Insurance Program for Fringe Benefits dated July 1, 1987.</p>
Pre-Existing Condition	<p>"Pre-Existing Condition" means an illness, injury, or condition (whether physical or mental) that existed within ninety (90) days before the Member's effective coverage under the Plan. An illness, injury, or condition is considered to have existed if the Member:</p> <ul style="list-style-type: none"> • Sought or received professional advice for that illness, injury, or condition. • Received medical care or Treatment for that illness, injury, or condition. • Received medical supplies, drugs, or medicines for that illness, injury, or condition. <p>In addition, a pregnancy will be considered a Pre-Existing Condition. For all purposes under the Plan, genetic information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to such information.</p>
Resource-Based	<p>"Resource-Based Relative Value Scale (or RBRVS)" means the</p>

Relative Value Scale (or RBRVS)	Medicare fee schedule used to determine an Allowable Charge and the Usual, Customary and Reasonable amounts as defined in the Plan.
Skilled Nursing Facility	“Skilled Nursing Facility” means 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.
Spouse	"Spouse" means an Employee's legally married husband or wife. The Plan Administrator may require other documentation to prove the legal existence of a marriage (e.g., a marriage license). The Employee shall have the sole burden of proving to the District the existence of a legal marriage and has the continuing obligation to inform the District of any termination of such marriage. Notwithstanding this Section 1.36 to the contrary, if an Employee has entered into a same-sex marriage that is legally recognized by the State of California, then for purposes of this definition, the term Spouse shall include the Employee's same-sex spouse in all instances under the Plan, except in those instances where U.S. federal law applies and fails to legally recognize the same-sex marriage. In instances where U.S. federal law applies, whether an Employee is legally married shall be determined under the Defense of Marriage Act, a U.S. federal law.
Treatment	"Treatment" means medical and surgical services generally recognized and accepted by the medical profession as the most appropriate method to treat the Member for his or her illness or injury.
Usual, Customary and Reasonable	"Usual, Customary and Reasonable" means the amount determined by the Plan to be the prevailing charge with Southern California – regardless of where the services are provided. This is based on RBRVS schedules, plus a particular percentage, as defined under "RBRVS" in the Plan. The Plan has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable.

XV. QUESTIONS
XVI.

PLEASE CALL THE FOLLOWING NUMBERS FOR HELP WITH YOUR QUESTIONS:

Claims/Customer Service Office	Local Nationwide (toll free)	858) 292-3542 (888) 233-7915
PPO Provider Network	Nationwide (toll free) Website:	(877) 942-7427 www.multiplan.com
Utilization Review Organization/Pre-Authorization Review	Nationwide (toll free)	(800) 262-4242
Express Scripts	Express Scripts Customer Service Pharmacy Help Desk Consortium Office	(888) 201-5853 (800) 235-4357 (858) 292-3542
Behavioral Health & Substance Abuse	Provider Network/ Guidance in Specialty Care	(800) 999-9585