

PALOMAR COMMUNITY COLLEGE PPO HEALTH PLAN

SUMMARY BOOKLET



This document is a summary of your district's Self-funded PPO Health Plan, which provides a brief description of The Plan. This summary of the Health Benefit Plan is not to be accepted or construed as a substitute for the provision of the master Plan Document. If questions arise, the Plan Document will govern. Benefits are paid based on eligible expenses.

PLEASE READ THIS BOOKLET CAREFULLY

**SAN DIEGO AND IMPERIAL COUNTY SCHOOLS
FRINGE BENEFITS CONSORTIUM
INSURANCE SERVICES, LLC**

Self-funded PPO Health Plan Benefit Highlights

MEMBER PAYS

CO-INSURANCE	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	\$5,000,000	

MEMBER PAYS

PROFESSIONAL SERVICES	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 max.)	10%	30%
Well-baby/child care* (immunizations are not part of the 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%
<i>*Based on frequency recommended by the American Medical Association and \$200 maximum in a calendar year.</i>		
Outpatient Rehabilitative Therapy - Utilization review required after 30 calendar days. Speech Therapy - Limited to treatment following surgery, injury, or non-congenital disease.	10%	30%

MEMBER PAYS

CARE FOR CONDITIONS OF PREGNANCY (professional services only)	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%

MEMBER PAYS

OTHER SERVICES	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%
Nuclear medicine	10%	30%
Chemotherapy	10%	30%
Renal dialysis	10%	30%
Home health visit - limited to 100 visits per calendar year. In and out-of-network limits combined.	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

	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

	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

THIS IS ONLY A SUMMARY OF THE COVERED BENEFITS AND SERVICES. PLEASE REFER TO COVERED SERVICES AND EXCLUSIONS AND LIMITATIONS SECTIONS IN THIS BOOKLET FOR DETAILED COVERAGE INFORMATION.

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YOUR CONSORTIUM HEALTH PLAN IS FLEXIBLE TO MEET YOUR NEEDS

WHAT IS THE PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK?

The Consortium contracts with MultiPlan/PHCS for the provider network. The provider network consists of participating physicians and hospitals nationwide. **You decide, at the time you need the services, whether or not to take advantage of added savings by using PPO physicians and Hospitals. A PPO Provider Directory is available on line at www.multiplan.com. The provider network is subject to change at any time. It is always important to verify with your provider or contact MultiPlan/PHCS at **(877) 942-7427** to ensure the provider you have selected is a part of the PPO network at the time you schedule an appointment or receive services.**

USING THE PPO NETWORK

Benefits for covered expenses charged by Participating Providers are based on negotiated rates. Participating Providers should not bill you for any difference between the negotiated rate and the actual cost of the service. You are responsible for any co-pays, annual deductible and coinsurance (which are also lower when you use a participating provider).

When you need surgery, remind your participating physician to request the services of participating providers as part of the surgical team to ensure benefits based on negotiated rate.

Benefits for covered expenses charged by Non-participating Providers are based on Usual, Customary and Reasonable allowances. Actual billed charges may be higher than the Consortium's customary and reasonable allowance. You are required to pay the provider for any difference between customary and reasonable allowance and the actual billed charges, in addition to your deductible for the year and your coinsurance.

HOW TO RECEIVE BENEFITS

ALWAYS SHOW YOUR IDENTIFICATION CARD

Most Physicians and Hospitals will bill the Consortium directly.

At the time you receive medical care, ask if the provider will bill for you. For Providers who do not bill directly, you must forward a fully itemized bill to the Consortium yourself. San Diego County Schools Fringe Benefits Consortium Medical Claim forms are available from your District benefits administrator.

Within 3 months after you have incurred expenses, the itemized charges and dates of service must be filed with the Consortium Claims Office.

CLAIMS WILL NOT BE PAID IF FILED IN EXCESS OF ONE YEAR FROM DATE OF SERVICE.

MAIL CLAIMS TO:

San Diego & Imperial County Schools
Fringe Benefits Consortium
PO Box 729
Buckeystown, MD 21717

QUESTIONS REGARDING BENEFITS:

(858) 292-3542 OR (888) 233-7915

PRE-EXISTING CONDITIONS

All newly hired or newly Eligible Employees and their dependents will have no benefits for any condition for which treatment was received during the ninety (90) days immediately preceding the Member's effective date of coverage under The Plan. Treatment includes taking medication. Any break in a district sponsored health plan will subject the employee to this pre-existing clause. This provision applies to newly adopted children and newly acquired spouses/domestic partners. This limitation ceases to apply to any Member after twelve (12) consecutive months of membership in The Plan.

This clause does not apply to a Member who was covered under another District sponsored health plan, nor does it apply to a Child born to a Member who is already enrolled in The Plan.

ELIGIBILITY/ENROLLMENT

All active employees according to eligibility as specified in bargaining unit contracts, Board Members, and early retirees are eligible for The Plan. The Plan becomes effective the first day of the month after the date of hire. **RETIREES MAY NOT ADD SPOUSE OR DEPENDENTS TO THE COVERAGE AFTER RETIREMENT.**

FAMILY ELIGIBILITY

The following are eligible as dependents of the Eligible Employee:

- Legally married spouse.
- Registered Domestic Partner as defined by The Plan. 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.
- Unmarried eligible Children, as defined by The Plan, to age 19.
- Unmarried eligible Children, as defined by The Plan, age 19 to 25 if full time student.

An unmarried enrolled Child, incapable of self-sustaining employment because of mental or physical impairment that occurred prior to reaching the age limit for unmarried 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.

FILING OF ENROLLMENT APPLICATION

1. Every Eligible Employee must file an enrollment application with The Plan.
2. Every Eligible Employee must file an application with The Plan within 31 days after becoming eligible for coverage. The application must include any eligible family Members.
3. The Eligible Employee must file an application to enroll a new Spouse within 31 days after marriage.
4. The Eligible Employee must file an application to enroll a new Domestic Partner within 31 days after the effective date of the Certified Declaration of Domestic Partnership or 31 days from meeting the eligibility listed above and completing an Affidavit of Domestic Partnership form.
5. The Eligible Employee must file an application to enroll a newly acquired Child within 31 days after the birth or the acquiring of the Child.
6. The Plan will honor "Qualified Medical Child Support Orders" (QMCSO) received from the District. As directed by the QMCSO, the eligible child(ren) to whom the order applies will be enrolled as dependent(s) of the Employee.
7. The Plan reserves the right to request proof of eligibility.

An Eligible Employee, the employee's spouse or domestic partner or dependent children who are not enrolled within 31 days of eligibility must wait for the next open enrollment period to enroll. This would be with the exception of enrollment determined to be due to a HIPAA special enrollment qualifying event.

EFFECTIVE DATES

Eligible Employee

- Coverage begins the first day of the month following the date of hire. If the date of hire falls on the first day of the month, coverage begins on the first day of the month.

Family Member

- If the application of an Eligible Employee includes application for an eligible Spouse, Domestic Partner or Child, coverage for that dependent begins on the Member's Effective Date.
- 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 an Eligible Employee already enrolled, coverage begins on the first day of the month following the date of Certified Declaration of Domestic Partnership or completion of an Affidavit of Domestic Partnership (given the domestic partners have meet the eligibility requirement), but only if an application for the domestic partner has been filed within 31 days of the Certified Declaration of Domestic Partnership or completion of an Affidavit of Domestic Partnership form.
- 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.
- The Plan will honor “Qualified Medical Child Support Orders” (QMCSO). As directed by the QMCSO, the eligible child(ren) to whom the order applies will be enrolled as dependent(s).

CANCELLATION OF COVERAGE

A Member's coverage is cancelled under the following conditions:

1. On the date the contract between the District and The Plan is cancelled.
2. On the next premium contribution due date after the Member no longer meets the eligibility requirements.
3. At the end of the period for which premium contributions charges have been paid when the required premium contributions for the next period are not paid by the employee; i.e., COBRA, leave of absence, or other instances where employee payroll deductions are not available.

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

CONVERSION

There are no conversion rights under The Plan upon termination of eligibility. Review the “Extension of Benefits” section for COBRA benefits. **DOMESTIC PARTNERS AND THEIR DEPENDENTS ARE NOT ELIGIBLE FOR COBRA CONTINUATION COVERAGE.**

DETERMINATION OF COVERED EXPENSE

A covered expense is incurred on the date the Member receives the service or supply. In no event will a covered expense include:

- 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/Reasonable 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.

SCHEDULE OF BENEFITS

LIFETIME MAXIMUM

\$5,000,000 per member

CALENDAR YEAR DEDUCTIBLE

\$100 per individual/\$200 per family

Covered expenses incurred during the last three months of a Calendar Year that are applied towards the deductible for that year will also be applied towards the deductible for the following year.

CALENDAR YEAR STOP-LOSS MAXIMUM

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

PAYMENT LEVELS/COINSURANCE

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 related Health Provider. Once a member reaches the out-of-network calendar year out-of-pocket maximum no further coinsurance will be required for the remainder of that calendar year.

Forced Providers

After the calendar year deductible is met, payment is provided at 90% of the billed charges for a covered expense when the member is unable to choose the services of a Participating Provider for the following list of provider 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 a PPO facility
- Inpatient Physician Hospital visits when member is confined in an inpatient PPO facility
- Anesthesiologist when the surgeon is a PPO provider
- Radiologist and laboratories when the patient 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

In Network

Payment is provided at 90% of the negotiated providers contracted rate, less any applicable co-payment (co-payments are shown on the benefits highlights) and deductible for covered charges incurred by a member for treatment in a Participating Hospital emergency room. Co-payment is waived if admitted directly into the hospital.

Out of Network

Payment is provided at 70% of the allowable charge, less any applicable co-payment (co-payments are shown on the benefits highlights) and deductible for covered expenses incurred by a member when using a Non-Participating Hospital emergency room. Co-payment is waived if admitted directly into the hospital.

Emergency room use requires a \$25 co-payment.

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.

Chiropractic Care/Acupuncture

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.

COVERED EXPENSES

HOSPITAL

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 is: a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient surgical center according to state and local laws and must meet all requirements of an outpatient surgical center providing surgical services.

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.

SKILLED NURSING FACILITY

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. Skilled Nursing benefits are a covered benefit only when the following are met:

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

Medically necessary covered services and supplies provided by a registered nurse, a licensed Therapist for physical therapy covered occupational therapy or covered speech therapy, a medical social service worker, a Licensed Vocational Nurse who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. Services of a Vocational Nurse 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 of a registered nurse or licensed Therapist. Custodial care is excluded. Home Health Care benefits are a covered benefit only when the following are met:

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).

OUTPATIENT REHABILITATIVE THERAPY

Medically necessary covered physical, occupations and speech therapy required to treat a Member's illness or injury. Coverage for Continued Physical Therapy is subject to utilization review after 30 calendar days.

PROFESSIONAL SERVICES

Medically necessary covered services provided by one of the following:

A Physician or Physician Assistant

An Anesthetist or a Certified Registered Nurse Anesthetist

Services of a midwife who is also a Licensed Registered Nurse acting within the scope of his/her license.

A Registered Nurse, Licensed Vocational Nurse or Nurse Practitioner

A Clinical Laboratory

Services of a licensed retail pharmacy

PREVENTIVE CARE

WELL-CHILD CARE (through age 18 years) – Physician, laboratory, radiology, immunizations, and related services in accordance with the American Academy of Pediatrics guidelines. Immunizations for occupational and/or travel purposes are not a covered benefit.

WELL-ADULT CARE – Physician, laboratory, radiology and related services in accordance with the American Medical Association guidelines. Adult immunizations and immunizations for occupational and/or travel purposes are not a covered benefit.

WELL-WOMAN CARE – Examination, including Pap smear and screening mammography.

CHIROPRACTIC CARE

Medically necessary services provided by a licensed Chiropractor.

ACUPUNCTURE CARE

Medically necessary services provided by a licensed Acupuncturist.

AMBULANCE SERVICES

The following ambulance services incurred by a member:

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.

ADDITIONAL COVERED 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 or 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 durable medical equipment and supplies which are:

1. ordered by a Physician,
2. of no further use when medical need ends,
3. usable only by the patient,
4. not primarily for the Member's comfort or hygiene,
5. not for environmental control,
6. not for exercise,
7. manufactured specifically for medical use.

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

Blood transfusions, including blood processing and the cost of un-replaced 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 lymphadema, is covered. Additionally, screening procedures, as recommended by the Member's Physician is covered. (In accordance with Woman's Health and Cancer Act.)

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:

- (1) Room and Board charged by the Hospice
- (2) Other covered Services and Supplies
- (3) Part-time nursing care by or supervised by a registered graduate nurse (R.N.) (L.V.N.) or (L.P.N)
- (4) Home Hospice Care Services provided by a Home Hospice Agency
- (5) Counseling for the Member and the Member's eligible dependents as provided through the outpatient mental and nervous provisions
- (6) Custodial care is excluded.

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

DENTAL CARE

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

Hospital stays for the purpose of administering general anesthesia are not a covered expense.

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.

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. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). (In accordance with Newborns' and Mothers' Health Protection Act).

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 premium, if any, are paid.

Termination of pregnancy.

Family planning services. Limited to one consultation per Member while eligible under The Plan.

ORGAN AND TISSUE TRANSPLANTS

Organ transplants are carved out of The Plan. This is a fully insured benefit, covered separately by AIG Life Insurance Company. AIG covers one-hundred percent (100%) of all in-network transplant-related organ procurement; Hospital, Physician and drug charges from the point a covered Member is diagnosed through 365 days post transplant procedure. In addition, out-of-network coverage is available, subject to policy limitations. For assistance please call 1 (800) 850-0920.

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 Schedule of Benefits for a complete summary of coverage.

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

CHRISTIAN SCIENCE BENEFITS

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

1. Maximum per hour: \$4.00
2. Maximum visit per day: One
3. Maximum hours per visit: 5
4. Maximum visits per Calendar Year: 70

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

1. Maximum per visit: 10.00
2. Maximum visit per day: One
3. Maximum visits per Calendar Year: 70

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 seventy (70) days per Calendar Year.

PLAN EXCLUSIONS AND LIMITATIONS

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

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

- Services or supplies that are not Medically Necessary as defined.
- Experimental or Investigative procedures, including any type of therapy not widely recognized as of value by the medical community and its societies, are not covered; all other charges, including but not limited to: office visits, laboratory procedures, or other related services incurred in conjunction with non-covered services, Treatment or therapy are also excluded. 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 the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends, except as specifically stated under Extension of Benefits.
- 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 Document as covered services.
- Services for which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:

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 the Member 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 the Member's home or who is related to the Member by blood or marriage or is part of the Immediate Family.
- 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 Covered Expenses.

- 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 Document.
- 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 Covered Expenses. 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. Eyeglasses or contact lenses, except as specifically stated under Covered Expenses. 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 Covered Expenses.
- Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.
- Cosmetic & 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, and
 - 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.

- Birth control devices.
- 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 required by employment or government authority.
- Services or supplies for the Treatment of an illness, disease or injury causing the Member to be Totally Disabled, if:
 - Coverage under The Plan Document 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, and
 - The Member is entitled to an extension of benefits in accordance with 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 provisions of the Coordination of Benefits section of The Plan Document.
- 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 except as specified under Covered Expenses
- 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.
- 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 Document.
- 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.).

PRESCRIPTION DRUG BENEFITS

PROVIDED BY EXPRESS SCRIPTS, INC.

This outpatient drug program provides benefits for medicine (including insulin) that requires a prescription when prescribed by a licensed physician. The Physician's prescription must be for the direct care and treatment of the Member's condition, be approved by the Food and Drug Administration (FDA) and dispensed within one year of being prescribed. The prescription must be purchased from a licensed retail pharmacy and not to be used while the Member is an inpatient in any facility, unless it is not usually supplied by or used in that facility.

At a participating pharmacy you pay a \$5.00 Generic/\$10.00 Brand co-pay for each covered prescription or refill. 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 or 100 units. Generic drugs are required unless a Physician specifically request a brand name.

A **90-day supply** of maintenance prescriptions is available through Express Scripts Mail Services Pharmacy with a **\$5.00 Generic/Brand co-pay** for each prescription.

DRUG EXCLUSIONS AND LIMITATIONS

- Medicines not requiring a prescription, except insulin.
- Contraceptive patches, injections or any other materials or devices.
- Vitamins regardless of Medical Necessity. (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 Members over 25 years of age, unless a physician certifies that the drug is for a Medically Necessary reason
- Charges for the administration of any drug.

- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use. (Except two pairs of medical support hose per year for a diagnosed peripheral vascular disorder).
- Prescriptions that a Member is 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 one 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.

UTILIZATION MANAGEMENT

The Utilization review program evaluates the medical necessity of care and the setting in which care is provided. This Plan requires utilization reviews for all non-emergency confinements in a hospital. Services that are Medically Necessary are certified for an appropriate period and monitored so that Member knows when it is no longer Medically Necessary to continue those services.

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.**

DON'T FORGET--- it's your responsibility!

HOW TO OBTAIN PRE-AUTHORIZATION

Physicians should initiate the pre-authorization review process by calling the utilization review organization at **(800) 262-4242**.

If the Member 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, the Member's Physician will be notified immediately. Written notice then will be sent to the Member, the Member's Physician and the provider of the service.

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

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 THE MEMBER'S 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, the following criteria must be met:

1. The appropriate utilization reviews must be performed. **When pre-authorization review is not performed as required for a Hospital admission, the Member shall have an additional \$300 deductible per admission.**
2. The services must be Medically Necessary.
 - Inpatient hospital benefits will be provided only when an inpatient stay is Medically Necessary.
 - If the Member proceeds with inpatient services that have been determined to be not Medically Necessary at any stage of the review process, benefits 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 the Member or the Member's Physician disagrees with The Plan's utilization management determination or questions how it was reached, reconsideration may be requested. Requests for reconsideration must be directed to the review agency that made the review determination. Written requests must include medical information that supports the Medical Necessity of the services.

If the Member does not receive a response to the request for reconsideration within 60 days it is automatically deemed denied.

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

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

PERSONAL CASE MANAGEMENT

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

The Plan will determine when personal case management will be offered. If The Plan determines that the Member's needs could be met more efficiently, an alternate treatment plan may be recommended. This may include providing benefits not otherwise specifically covered under The Plan. The Plan provides these services at its sole option. The Member does not have a right to request personal case management.

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

COORDINATION OF BENEFITS

When a Member has more than one group or group-type health plan the following rules are used to determine the order in which benefits are paid.

1. A plan that has no coordination of benefits provision pays before a plan that has a coordination of benefits provision.
2. A plan on which the covered individual is a Member pays before a plan on which the covered individual is a dependent.
3. The plan that covers the individual as an active employee pays before the plan that covers the individual as a retiree.
4. A plan on which the covered individual is the Child of a Member whose birthday occurs first after the beginning of a Calendar Year pays before a plan on which the covered individual is the Child of a Member whose birthday occurs second in the Calendar Year except:
 - When the parents are separated or divorced and the parent with custody of the Child has not remarried, the plan that covers the Child as a dependent of the parent with custody pays first.
 - When the parents are divorced and the parent with custody of the Child has remarried, the plan which covers the Child as a dependent of the parent with custody pays before a plan which covers the Child as a dependent of the stepparent, and a plan which covers the Child as a dependent of the stepparent pays before a plan which covers the Child as a dependent of the parent without custody.
 - Regardless of the above, if there is a court decree which establishes a parent's financial responsibility for the Child's health care expenses, that financially responsible parent's plan pays first.
5. Coordination of Benefit provisions of The Plan are excluded for Health Maintenance Organization (HMO) plans when a Member is also a Member of the HMO, whether as a member or dependent, whether the HMO is qualified or not, regardless of the model of the HMO. 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.

6. 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.

In no event will benefits be paid in excess of 100% of charges for actual covered services.

MEDICARE COORDINATION

A BENEFIT MAY BE PROVIDED UNDER BOTH MEDICARE AND THE PLAN.

Occasionally a covered person becomes eligible under Medicare prior to age 65, and the federal government's Medicare program will pay for some of the same hospital and medical expenses, which are covered under The Plan. However, Medicare will pay its benefits first for retired members and The Plan will pay secondary. **For members still actively at work, The Plan will pay primary.**

THE ORDER OF BENEFIT DETERMINATION ALWAYS DEPENDS ON THE STATUS OF THE COVERED MEMBER.

A **retired** Health Plan member may qualify for Medicare benefits. When this occurs, The Plan will pay secondary to Medicare. Benefits that are available under Medicare will be deducted from the amounts payable for any retired person eligible under Medicare, regardless of whether that retired person has enrolled in Medicare. **If a retired person elects not to enroll in Medicare, The Plan will estimate the amount Medicare would have paid and pay as secondary.**

REIMBURSEMENT TO OTHER PLANS

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

SUBROGATION

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

Liens

1. The Plan shall automatically have a lien, to the extent of benefits advanced, upon any recovery, whether by settlement, judgment or otherwise that the Member receives from the third party, the third party's insurer, or the third party's guarantor. The lien shall be in the amount of paid benefits paid by The Plan under the Plan Document for the treatment of the illness, disease, injury or condition for which the third party is liable, in first priority. The Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by The Plan Member.
2. The Member agrees to advise the Health Plan, in writing, within 60 days of their 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 Document. Failure of the Member to give such notice to The Plan or to 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 Document and will result in the Member being personally responsible for reimbursing The Plan.
3. If the Health Plan needs legal authority to enforce its lien, the Member shall reimburse the Health Plan for the reasonable costs of collection including attorney's fees

Right of Recovery

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

If a covered person or dependent receives any recovery, by way of 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).

APPEAL RIGHTS

The Health Benefit Plan Document provides that treatment or service 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 San Diego County Schools Fringe Benefits Consortium has the responsibility for determining whether claims are payable. American Health Holdings, who is the utilization review company, must agree if the denial is based on lack of Medical Necessity.

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

APPEAL PROCEDURE

If a Member does not agree, either the Primary Member or the Member's attending Physician, at the written request of the Primary Member, may request reconsideration. This request must be made in writing within sixty (60) days of the denial of the Claim and must give the reasons the appealing party believes the denied Claim should be paid. The Primary Member and/or the Physician are entitled to review all documents pertinent to the denial of the Claim.

If the Consortium either affirms the original denial of the Claim, or fails to respond within sixty (60) days after receiving the request for reconsideration (or within one-hundred, twenty (120) days, if within the first sixty (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 ninety (90) days of receiving the final denial or the time for responding by the Consortium has expired.

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 Primary Member must initiate arbitration in accordance with California law and in compliance with the rules established by the American Arbitration Association. This request for arbitration must be in writing to the Consortium. The applicant is responsible for the administrative filing fee as established by the American Arbitration Association. Small Claims service or request for arbitration shall be made to:

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

Under The Plan the Primary Member has substituted their right to trial by court or jury with binding arbitration as to the dispute.

GENERAL PROVISIONS

PROTECTION OF COVERAGE

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

- The Plan Document is still in effect
- The Member is still eligible, and
- The Member's contributions are paid according to the terms of The Plan.

MAILING ADDRESS

Any notice required of the Health Plan will be mailed to the following address:

San Diego & Imperial County Schools
Fringe Benefits Consortium
6401 Linda Vista Rd., # 505
San Diego, CA 92111-7399

CLERICAL ERRORS/ADMINISTRATIVE ERRORS

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

PROVIDING OF CARE

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

NON-REGULATION OF PROVIDERS

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

BENEFITS NOT TRANSFERABLE

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

INDEPENDENT CONTRACTORS

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

MEDICALLY NECESSARY

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

EXPENSE IN EXCESS OF BENEFITS

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

AREA OF SERVICE

The benefits of The Plan are provided for covered services received anywhere in the world, but are limited to those services that are defined as Medically Necessary.

PAYMENT TO PROVIDERS

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

RECEIPT OF CLAIM

Properly completed forms or universally accepted medical forms itemizing the charge for the services received must be sent to, and received by The Plan, either by the Member or the provider of service. A

claim must be **received** by The Plan within three (3) months but never later than twelve (12) months of the date services are rendered. The Plan will not consider, and is not liable for any benefits if claims are not received within this time period. This provision applies regardless of the reason why the claim is not received in a timely manner. It is not The Plan's responsibility to obtain a claim. It is ultimately the Member's responsibility to ensure that all claims are received within the filing limit. Fully itemized forms must be used: canceled checks, receipts or balance due statements are not acceptable. All claims must be filed in English and in U. S. currency.

RIGHT TO RECEIVE NECESSARY INFORMATION

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

PROTECTED HEALTH INFORMATION

The "Superintendent," as the administrator of The Plan, or his/her designee is the custodian of records of The Plan. Any private health information of a member shall be protected by the custodian of records of The Plan. The protections apply whether the information is transmitted or maintained electronically, on paper or verbally. 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.

RIGHT OF RECOVERY

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

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

FREE CHOICE OF HOSPITAL AND PHYSICIAN

The Plan in no way interferes with the right of any person entitled to hospital benefits to select the hospital of their choice. That person may choose any physician who holds a valid physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. However, benefits payable according to the terms of The Plan will be different for Non-Participating Hospitals or Non-Participating Physicians than those benefits payable for Participating Hospitals or Participating Physicians.

NEWBORNS' AND MOTHERS' PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998. On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

EXTENSION OF BENEFITS

COBRA

The District is required to make temporary continued health plan coverage available for certain employees and dependents under COBRA.

The right to continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. **Domestic Partners and their dependents are not eligible for Federal COBRA continuation coverage.**

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 section. 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 must pay for COBRA continuation coverage. Premiums are based on group rates plus a 2% administration fee.

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)
- You become divorced or legally separated from your spouse

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 legally separated
- 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 District's designated employee benefits administrator has been notified that a qualifying event has occurred. When

the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer is responsible for ensuring that a COBRA election notification, "Qualifying Event Notice", is provided to the qualified beneficiaries.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the required notification to the District's designated employee benefits administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the District's designated employee benefits administrator receives the required notification that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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 and you notify the District's designated employee benefits administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Legislation allows premiums of up to 150% of group rates for the 19th through the 29th month. Notification and documentation from social security must be provided within 60 days of the latest of (1) the date of the Social Security Administration's disability determination, (2) the date of the qualifying event, (3) the date on which the qualified beneficiary would lose coverage under the plan.

2. Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to District's designated employee benefits administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the District's designated employee benefits administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the District's designated employee benefits administrator.

COBRA Coverage Ceases on the Earliest of the Following

1. 18 months after the date of termination of the employee's employment (other than for gross misconduct) or reduction of hours worked which renders the employee ineligible for coverage. If an employee, spouse or dependent child is determined to have been disabled for Social Security purposes at the time of the qualifying event or any time during the first 60 days of COBRA coverage, the continuation coverage may extend to twenty-nine (29) months for all qualified beneficiaries. Also, a second qualifying event, occurring during the initial 18 months, could extend coverage up to a maximum of 36 months for a spouse or dependent children who are qualified beneficiaries.
2. 36 months after the date of any other qualifying event.
3. For spouse and dependent children, 36 months after the date of Medicare entitlement when the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event.
4. The date on which the District ceases to provide any group health plan to employees.
5. The date on which coverage ceases under the plan by reason of a failure to make timely payment required under the Plan with respect to the qualified beneficiaries.
6. The date on which the qualified beneficiary first becomes covered under another group health plan that does not include a preexisting conditions clause that is applicable.
7. The qualified beneficiary becomes entitled under Medicare.

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

TOTALLY DISABLED

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

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

NOTE: Extension of Benefits shall not be provided if the Member is required to pay the whole or any part of the premium charges required under the terms of The Plan and such Member ceases

to pay such premium charges while The Plan is in effect. COBRA coverage will not be extended beyond the maximum COBRA periods, even if a Member is Totally Disabled.

EDUCATION CODE SECTION 7000/AB528

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

WHEN YOU ARE TRAVELING

Your Consortium health benefits are provided for care received anywhere in the world.

INSIDE THE UNITED STATES

If you are a bed patient in any of the contracting hospitals, the hospital will process your bill. Outpatient hospital bills and all other bills should be sent to the San Diego & Imperial Schools Fringe Benefits Consortium Claims Office.

OUTSIDE THE UNITED STATES

In a foreign country, you may have to pay the bill and then be reimbursed by The Plan. If you do require medical care, ask for an itemized bill written in English and converted to U. S. currency.

Claim forms are available from your District benefits administrator.

HEALTH INSURANCE PORTABILITY ACT OF 1996 (HIPAA)

Federal laws regarding portability of coverage, maternity stays and mental health benefits were passed in the Health Insurance Portability Act of 1996.

SPECIAL ENROLLMENT

If an employee is declining enrollment for themselves or their dependents because of other health insurance coverage, they may in the future be able to enroll themselves or their dependents in The Plan, provided that they request enrollment within 30 days after the other coverage ends. In addition, if they have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption, they may be able to enroll themselves and their dependents, provided that they request enrollment within 30 days from the marriage, domestic partnership, birth, adoption or placement for adoption.

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.

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 who 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 labeled “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 & 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 under the Health Insurance Portability & Accountability Act of 1966 (HIPAA) to maintain the privacy of our protected health information. The Plan has appointed a privacy officer and each member of the privacy implementation team has been properly trained to perform his/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 so long as it remains in effect. The Plan reserves the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information 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:

Location: San Diego & Imperial County Schools Fringe Benefits Consortium
Address: 6401 Linda Vista Road, #505, San Diego, CA 92111-7399
Telephone: (858) 569-5347
Website Address: <http://www.sdcoe.k12.ca.us/business2/risk/hippa/palomar.pdf>
Contact Person or Department: Fringe Benefits Consortium, Privacy Officer

DEFINITIONS

Accidental Injury is physical harm or disability, which is the result of a specific unexpected incident caused by an external force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except illness or infection of a cut or wound that is a result of an Accidental Injury. Employment - related injury/illness are excluded.

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

Calendar Year is 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.

Child is the Employee's biological Child, stepchild, legally adopted Child, or a Child placed for adoption for whom the Employee assumes and retains legal obligation for total or partial support. A stepchild would include the biological child or the adopted child of the employee's spouse or domestic partner. Additionally, a covered Child is one for whom a covered employee or the employee's spouse or domestic partner has been appointed legal guardian when the Child lives with, and depends upon, the employee for care and support.

Claim is a fully itemized bill submitted by either the Member or the provider of service. All Claims must fully itemize the services rendered, in English, using CPT, CRVS, or RBRVS codes. All Claims must be submitted on properly completed forms or universally completed forms in U.S Dollars. All Claims must be received by The Plan within three (3) months, but never later than twelve (12) months from the date services are rendered.

COBRA is an acronym for Consolidated Omnibus Budget Reconciliation Act.

CUSTODIAL CARE is care provided primarily to meet the personal needs of the Member and/or that which does not require skilled medical personnel to perform. This includes, but is not limited to, help in getting in and out of bed, walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine, which is usually self-administered, or any other care or activities of daily living which do not require the services of licensed medical personnel.

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

Domestic Partners are "two adults who have filed a valid Declaration of Domestic Partnership with the State of California. Each District's Board policy may dictate whether eligibility is extended to opposite sex partners, same sex partners, or both, and the type of documentation The Plan may require as proof of a Domestic Partnership.

Effective Date is the date the Member's coverage under The Plan Document begins.

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:

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

Family Member is the Employee's enrolled lawful Spouse, and each enrolled eligible Child. A Family Member includes an enrolled Domestic Partner.

Full-time Student Status is considered equivalent to twelve (12) units of credit from an Accredited Educational Institution. Vocational and Trade Schools may entitle a dependent to be considered a Full-time Student if the majority, (e.g., 6 hours daily of an 8 hour day), of the instruction is in a classroom/lecture setting.

Hospital is a facility that provides diagnosis, Treatment and care of persons who need acute Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association, and meet accreditation standards of the Joint Commission on Accreditation of Hospitals (This standard applies to Hospitals within the United States only).

Participating Hospital is a Hospital that has a Participating Agreement in effect with The Plan at the time services are rendered. Participating Hospitals agree to a payment rate that has been negotiated with The Plan as payment in full. 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

Non-Participating Hospital is a Hospital that does not have an Agreement with The Plan in effect at the time services are rendered.

Immediate Family means a Member or any eligible dependents that are covered under The Plan.

Medically Necessary care and Treatment 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. All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medically Determinable Impairment a medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities that can be shown to exist by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, and not solely by the individual's statement of symptoms.

Medicare Health Insurance for the Aged and Disabled is health insurance established by Title I of Public Law 89-98, including Title XVIII of the Social Security Act, as amended from time to time.

Member is the Employee, retiree and/or dependents enrolled according to the eligibility stated in The Plan Document.

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 International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Negotiated Rate is the fee Participating Hospitals and Participating Physicians agree to accept as payment in full for covered services.

Out-of Area is all covered services incurred outside the State of California

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 is duly licensed to prescribe and administer drugs and to perform surgery within the scope of his/her license, or a provider listed below.

Participating Physician is a Physician who has a Participating Agreement in effect with The Plan or its agents at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for covered services.

Non-Eligible Physician is a Physician who is of a specialty with which The Plan or its agents do not currently enter into Participating Agreements.

Non-Participating Physician is a Physician who is eligible to enter into a Participating Agreement with The Plan or its agents but who does not have a Participating Agreement in effect with The Plan or its agents at the time services are rendered.

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 above.

- A dentist (D.D.S.)
- An optometrist (O.D.)
- A dispensing optician
- A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- A psychologist
- A chiropractor (D.C.)
- An acupuncturist (but only for acupuncture and for no other services)
- A clinical social worker (C.S.W. or L.C.S.W.)
- A marriage, family and Child counselor (M.F.C.C.)
- A physical therapist (P.T. or R.P.T.)
- A speech pathologist
- An audiologist
- An occupational therapist (O.R.T.)
- A Physician assistant

Plan Document is the formal written document, which describes The plan of benefits and the provisions under which such benefits will be paid to covered Members, including any exhibits.

Plan Document Date is the date The Plan Document comes into effect.

Pre-existing Condition is an illness, injury or condition that existed within ninety (90) days before the Member's Effective Date. An illness, injury, or condition is considered to have existed when the Member:

- 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.

a pregnancy will be considered a Pre-existing Condition.

Primary Member Refers to the Employee, former Employee, or a COBRA participant who is enrolled under his or her own Member identification number.

Resourced-Based Relative Value Scale (RBRVS) is the Medicare fee schedule used to determine an Allowable Charge and customary amounts as defined in this document.

San Diego County Schools Fringe Benefits Consortium Health Benefit Plan is the name of the plan that provides benefits described by The Plan Document. Reference to that name includes all contracting agencies providing benefits under The Plan.

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a Skilled Nursing Facility under Medicare law.

Special Care Units are special areas of a Hospital, which have highly skilled personnel and special equipment for acute conditions that require constant Treatment and observation.

Spouse is the Member's Spouse under a legally valid marriage between persons of the opposite sex.

Superintendent is the San Diego County Superintendent of Schools who is the authorized agent of the San Diego County Schools Fringe Benefits Consortium.

The Plan refers to the San Diego and Imperial County Schools Fringe Benefits Consortium Health Benefits Plan.

Total Disability is defined as the Member's inability to do **any** kind of substantial gainful work because of a physical or mental impairment (or a combination of impairments), which is expected to last at least twelve (12) months or end in death. If, because of a medical condition, a Member cannot do the work that they performed in the past, then age, education, and past work experience must be considered in determining whether the person can perform other duties. If the evidence shows that the person can perform other duties, even if such duties involve different skills or the compensation is less than that of the previous work, such Member cannot be considered disabled. (The Plan has modeled this provision on the Social Security Administration's definition of "Disability".)

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

Treatment means medical and surgical services generally recognized and accepted by the medical profession as the most appropriate covered Treatment for the illness or injury of a Member.

Usual, Customary and Reasonable charge is the amount determined by The Plan to be the prevailing charge within Southern California - regardless of where the services are provided. This is based on RBRVS schedules, plus a particular percentage, as defined above under "RBRVS." The Plan has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable.

QUESTIONS?

PLEASE CALL THE FOLLOWING NUMBERS FOR HELP WITH YOUR QUESTIONS:

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

READ THIS BROCHURE CAREFULLY, IT PROVIDES A BRIEF DESCRIPTION OF THE PLAN. This brochure does not create or confer any rights. It is a summary of the health benefit plan and is not to be accepted or construed as a substitute for the provision of the master Plan Document. It does not waive or alter any of the terms of the Plan Document. If questions arise, the Plan Document will govern. Benefits are paid based on eligible expenses.

Revised for January 2008