LOS ALAMITOS UNIFIED SCHOOL DISTRICT
EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Restated: July 1, 2017
Amended: July 1, 2018
Amended: March 1, 2020
Amended: July 1, 2020

DIRECTORY OF PLAN PROVIDERS

CONTRACT ADMINISTRATOR
Benefit and Risk Management Services, Inc. (BRMS)
80 Iron Point Circle, Suite 200
Folsom, CA 95630
(800) 372-0905

ANTHEM/BLUE CROSS NETWORK-PHYSICIAN FINDER
www.Anthem.com/ca
(800) 372-0905

UTILIZATION MANAGEMENT ORGANIZATION (Inpatient Hospitalization Pre-Service Review)
Anthem/Blue Cross
(800) 274-7767

UTILIZATION MANAGEMENT ORGANIZATION (Non-emergency outpatient care or any service costing more than $1,000)
Benefit & Risk Management Services (BRMS)
(800) 368-0767

PRESCRIPTION DRUG VENDOR
American Health Care
(800) 872-8276
http://www.americanhealthcare.com

SPECIALTY PRESCRIPTION DRUG VENDOR
Briova
1-855-427-4682
http://www.briovarx.com

MAIL ORDER PHARMACY MEMBER SERVICES
OptumRx
1-800-881-1966
http://www.optumrx.com

MEDICAL EYE SERVICES OF CALIFORNIA (MES)
(800) 877-6372
http://www.mesvision.com

DENTAL PROVIDERS

Blue Cross Dental Net
(800) 627-0004
www.Anthem.com/ca

Delta Dental - Direct
(800)765-6003
http://deltadentalca.org/

INSURANCE CONSULTANT
Sandy Best
BB&T – John Burnham Insurance Services
750 B Street, Suite 2400
San Diego, CA 92101
(951) 312-8547

Los Alamitos USD DISTRICT CONTACT
District
(562) 799-4700, 80409

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GENERAL PLAN INFORMATION

What is the purpose of the Plan?
The Plan Sponsor has established the Plan for your benefit, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible employees who are participants in the Plan and their eligible dependents, the economic effects arising from an injury or illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and the Plan Administrator must abide by the terms of the summary plan description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The Plan is not a contract of employment between you and your participating employer and does not give you the right to be retained in the service of your participating employer. The receipt of this summary plan description, by itself, does not establish eligibility or participation in the Plan.

The purpose of this summary plan description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of specified medical expenses. The summary plan description is maintained by the Plan Administrator and may be inspected at any time during normal working hours by any covered person.

This Los Alamitos Unified School District Employee Benefit Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverages that were already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

General Plan Information You Should Know

Name of Plan:	**Los Alamitos Unified School District Employee Benefit Plan**
Plan Sponsor/Administrator: **Agent for legal service**	**Los Alamitos Unified School District** **10293 Bloomfield Street** **Los Alamitos, CA 90720** **(562) 799-4700**
Fiscal Plan Year:	**July 1 through June 30**
Plan Type:	**Medical** **Prescription Drug**
Third Party Administrator:	**Benefit & Risk Management Services (BRMS)** **80 Iron Point Circle, Suite 200** **Folsom, CA 95630** **(800) 372-0905**

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the Plan?

1. Full-time Classified-CSEA, Certificated-LAEA, Confidential, Supervisory, Management Employees

As a full-time employee you are eligible to receive medical, dental, vision and life insurance based upon costs agreed to during negotiations.

2. Part-Time Certificated-LAEA, Confidential, Supervisory, Management Employees

As a part-time certificated, confidential, supervisory, or management employee (i.e., ***.50 Full-time equivalent [FTE]/20 hours or more***) you are eligible to receive employee-only medical insurance based upon costs agreed to during negotiations. Other types of insurance may be made available at the actuarial cost.

3. Part-Time Classified-CSEA

As a part-time classified employee (i.e., ***.75 FTE/30 hours or more***) you are eligible to receive employee-only medical insurance based upon costs agreed to during negotiations. Other types of insurance may be made available at the actuarial cost. (NOTE: Employees working 20 hours or more but less than full-time and receiving employee-only medical coverage prior to July 1, 2016 shall be grandfathered to continue to receive employee-only medical coverage by the District as long as they maintain working at least .5 FTE for the District.)

When do I become eligible to participate in the Plan?

NEW EMPLOYEES

As a new employee to the District who meets the FTE level of work stated above, you are eligible for coverage on the latter of the:

- date you meet the eligibility requirements; you're eligible to come on the plan on the first day of the month following 60-days on active payroll.
- date you enroll in the Plan.

You must actually begin work for the District at the required FTE level in order to be eligible. If you are unable to begin work as scheduled, your coverage will be delayed; once you begin work, you will eligible as stated above.

CURRENT EMPLOYEES WHO INCREASE THEIR FTE/NUMBER OF HOURS WORKED LEVEL

As a current District employee, if your FTE/Number of hours increases due to an increase in hours or job change, you are eligible for coverage on the latter of the:

- date you meet the eligibility requirements; you're eligible to come on the plan on the first day you are on active payroll in the qualifying FTE level providing you have been an active employee in the District for at least 60 days.
- date you enroll in the Plan.

OTHERS

You are not eligible to participate if you are a temporary, leased or seasonal employee, or an independent contractor.

Are my dependents eligible to participate in the Plan?
Your dependents will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage
- The date coverage for dependents first becomes available under the Plan
- The first date upon which you acquire a dependent

Please note: You must be covered under the Plan in order to cover any dependents.

"**Michelle's Law Extension**" means the extension of coverage to full-time student dependents who experience a medically necessary leave of absence, for up to one year, if both of the following conditions are met:

- The Plan receives written certification from the dependent's treating physician certifying that:
  - The dependent is suffering from a serious illness or injury; and
  - The leave of absence from the postsecondary institution is a medically necessary leave of absence.

The one-year period begins with the first day of the medically necessary leave of absence and may end before the year ends, if the dependent's coverage under the Plan would terminate for any reason.

When will we become covered persons in the plan?
Coverage will become effective at 12:01 A.M. (except for newborn children) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the first day following the date you or your dependents are eligible, provided you and your dependents have enrolled for coverage on a form satisfactory to the Plan Administrator within 31 days following the date of eligibility.
- For a dependent child who is born after the date your coverage becomes effective:

  The dependent child will be covered from the moment of birth for 31 days. If you wish to continue coverage beyond this 31-day period, you must make written application for coverage and agree to any required contribution **during the first 31-day period from birth**.

If you acquire a dependent while you are eligible for coverage for dependents, coverage for the newly acquired dependent will be effective on the date the dependent becomes eligible, provided you make written application for the dependent and agree to make any required contributions, within 31 days of the date of eligibility.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?
If you did not enroll during your original 31-day eligibility period, and have now decided to apply for coverage, you may do so at the next scheduled open enrollment period. Likewise, if you declined to enroll any of your eligible dependents during the original enrollment period, you may apply for coverage for them at the next open enrollment period.

Effect of Section 125 Tax Regulations on this Plan:
It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations there under and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the District nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Are there any other exceptions for enrollment?

Loss of Other Coverage

If you declined enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your dependents if the other health coverage is lost. You must make written application for special enrollment within 31 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Plan Administrator and apply for coverage by close of business on October 16.

The following conditions apply to any eligible employee and dependents:

You may enroll during this enrollment period

- If you are eligible for coverage under the terms of this Plan
- You are not currently enrolled under the Plan
- When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. You must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan, and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a dependent of that employee has a special enrollment right in the Plan because the dependent lost eligibility for other coverage. You must make written application for special enrollment in the new benefit package within 31 days of the date the other health coverage was lost.

You are not eligible for this enrollment right if:

- The other coverage was COBRA continuation coverage and you did not exhaust the maximum time available to you for that COBRA coverage, or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for enrollment are satisfied, coverage for you and/or your dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

New Dependent

If you acquire a new dependent as a result of marriage, birth, adoption, legal guardianship, or placement for adoption, you may be able to enroll yourself and your dependents during a special enrollment period. You must make written application for special enrollment no later than 31 days after you acquire the new dependent. For example, if you are married on September 15, you must notify the Plan Administrator and apply for coverage by close of business on October 16.

The following conditions apply to any eligible employee and dependents:

You may enroll yourself and/or your eligible dependents during this enrollment period if:

- You are eligible for coverage under the terms of this Plan, and
- You have acquired a new dependent through marriage, birth, adoption, legal guardianship, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your dependent(s) will be effective at 12:01 A.M.:

- For a marriage, on the date of the marriage.
- For a birth, on the date of birth.
- For an adoption, legal guardianship, or placement for adoption, on the date of the adoption or placement for adoption.

With respect to a dependent up to age 26, pursuant to the Patient Protection and Affordable Care Act (PPACA), PPACA requires this plan to continue to make dependent coverage available up to age 26. Coverage need not be offered to a dependent up to age 26 that is covered under their own Group Health Plan.

Special Enrollment Rights (CHIPRA – Children Health Insurance Plan Reauthorization Act)
Employees and dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

- The employee's or dependent's Medicaid or State Child Health Insurance Plan (*i.e.*, CHIP) coverage has terminated as a result of loss of eligibility and the employee requests coverage under the Plan within 60 days after the termination; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (*i.e.*, CHIP), and the employee requests coverage under the Plan within 60 days after eligibility is determined.

What if a court orders coverage for a child?
Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a "medical child support order" ("MCSO") or "national medical support notice" ("NMSN") that is a "qualified medical child support order" ("QMCSO") if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

"Alternate recipient" shall mean any child of a covered person who is recognized under a MCSO as having a right to enrollment under this Plan as the covered person's eligible dependent. "MCSO" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a covered person's child or directs the covered person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan

"NMSN" shall mean a notice that contains the following information:

- Name of an issuing state agency
- Name and mailing address (if any) of an employee who is a covered person under the Plan
- Name and mailing address of one or more alternate recipients (i.e.,, the child or children of the covered person or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients(s))

- Identity of an underlying child support order

"QMCSO" is an MCSO that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a covered person or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the covered person and the name and mailing address of each alternate recipient covered by the order
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined
- The period of coverage to which the order pertains
- The name of this Plan

In addition, a NMSN shall be deemed a QMCSO if it:

- Contains the information set forth above in the definition of "NMSN";
  - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the employer and the Plan Administrator will assume that all are designated; or
  - Informs the Plan Administrator that, if a group health plan has multiple options and the covered person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to covered persons without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSO's, as described in Social Security Act Section 1908.

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

- Notify the covered person and each alternate recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO; and
- Make an administrative determination if the order is a QMCSO and notify the covered person and each affected alternate recipient of such determination.

Upon receiving a NMSN, the Plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
  - Whether the child is covered under the Plan; and

- Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage

- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage

To give effect to this requirement, the Plan Administrator shall:

- Establish reasonable, written procedures for determining the qualified status of a MCSO or NMSN; and

- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the order.

What if I was covered under a prior plan?
Any waiting period limitation previously satisfied under the prior health plan will be applied toward satisfaction of the waiting period limitation of this Plan.

A HIPAA certification of creditable coverage will be required for any "late enrollees" as proof of covered status.

Changing status
When you change your coverage status between that of an employee and a dependent, and there is no break in coverage, full credit will be given for any amounts applied toward satisfaction of the current plan year deductible and out-of-pocket expense limit, and any amounts applied toward Plan maximums will be carried forward.

Dual Coverage
If both you and your spouse/partner work at LAUSD you may not cover your partner/spouse as a dependent. Also, only one of you can cover any dependent children.

Extension of Coverage for Retirees
The Plan will continue to offer some or all of the Plan coverages to certain Employees who retire from Active Service for the Employer. For Retirees under the age of 65, such coverage may be offered under the same terms of a negotiated collective bargaining agreement, or an agreement approved by the Board of Education. For certificated Retirees age 65 or older, Plan coverages may be available in accordance with California Assembly Bill No. 528.

PRE-EXISTING CONDITIONS LIMITATIONS

Effective January 1, 2014 the Affordable Care Act removes all pre-existing condition limitations. The Plan cannot deny coverage or otherwise limit or exclude benefits based on the fact that a condition was present before coverage became effective, regardless of whether the individual previously received diagnosis, care or treatment for the condition.

SELECTION OF YOUR HEALTH CARE PROVIDER

Overview of PPO/Non-PPO Option

The Plan Administrator has entered into an agreement with one or more networks of hospitals and physicians, called preferred provider organization networks or "PPO networks." These PPO networks offer covered persons health care services at discounted rates. Using a PPO network provider will normally result in a lower cost to the Plan as well as to the covered person. There is no requirement for any covered person to seek care from a provider who participates in the PPO network. The choice of provider is entirely up to the covered person.

If you reside outside the PPO network area, (25 miles from the nearest PPO hospital or PPO physician), and use a non-PPO network provider, your benefits will be based on the "Out of Area" level shown in the "Schedule of Benefits." This also applies to dependent children who are covered by this Plan, and reside outside the network area.

Services which are covered by this Plan and which are **not available** through a PPO network provider are paid at the PPO network provider percentage payable for usual, customary and reasonable fees, even when the services are provided by an non-PPO network provider.

Services provided through a referral by PPO network provider hospital, which are rendered and billed by a non-PPO network provider, are reimbursed at the PPO network provider percentage payable for usual, customary and reasonable fees.

Some PPO network provider hospitals have arrangements through which the benefit payable is more than the actual charges, i.e., per diem or diagnosis-related group (DRG) charges. When this occurs, the Plan will reimburse the hospital based upon the agreed per diem or DRG rates.

A current list of PPO network providers is available, without charge, through the third party administrator. You may also contact your PPO network at the phone number on your Plan ID card.

Each covered person has a free choice of any provider, and the covered person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO network provider.

Many PPO network providers will require that the Plan offer incentives, or "steerage," in order to encourage covered persons to use their member providers. This Plan defines "steerage" as lower costs to the covered person through reduced charges, resulting in lower out-of-pocket amounts, or higher rates of reimbursement under the Plan. The Plan Administrator reserves the right to negotiate discounts with providers of service, and those discounts will be used to reduce the amount of otherwise covered expenses considered for payment by the Plan. In certain cases, the Plan Administrator, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the PPO network provider reimbursement level, and such payments will be considered to be in full compliance with the terms of the Plan.

YOUR COSTS

You must pay for a certain portion of the cost of covered expenses under the Plan, including deductibles, copayments and the coinsurance percentage that is not paid by the Plan. This is called "out-of-pocket expense."

Deductibles and copayments are shown in the "Schedule of Benefits." A separate deductible applies to charges from PPO network providers and another for non-PPO network providers. If you use a combination of PPO network providers and non-PPO network providers, your total deductible amount required will not exceed the amount shown for non-PPO network providers. In other words, the amount of deductible expense you pay for both PPO network providers and non-PPO network providers will be combined, and the total will not exceed the amount shown for non-PPO network providers during a single plan year. The Plan limits the amount of deductible and out-of-pocket expense you must pay for your family unit, as shown in the "Schedule of Benefits."

There may be differences in the coinsurance percentage payable by the Plan depending upon whether you are using a PPO network provider or a non-PPO network provider. These payment levels are also shown in the "Schedule of Benefits."

The Plan contains a limit for the amount of out-of-pocket expense you must pay toward covered expenses, shown in the "Schedule of Benefits," and your out-of-pocket expense limit may be higher for non-PPO network providers than for PPO network providers.

Reimbursement for these types of covered expenses will continue at the percentage payable shown in the "Schedule of Benefits," subject to the Plan maximums.

In addition, certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the "Schedule of Benefits" section. Expenses in excess of these plan limits will not accumulate toward the out-of-pocket expense limit.

Once you have paid the out-of-pocket expense limit for eligible expenses incurred during a plan year, the Plan will reimburse additional eligible covered expenses incurred during that year at 100%.

The Plan will not reimburse any expense that is not a covered expense. In addition, you must pay any expenses to which you have agreed that are in excess of the usual, customary and reasonable fees, and any penalties for failure to comply with requirements of the "Cost Containment Provisions" section or penalties that are otherwise stated in the Plan. None of these amounts will accumulate toward your out-of-pocket expense limit.

Although there may be circumstances when a Network provider cannot be used, Non-Network providers will be paid at the Non-Network benefit levels EXCEPT in the following instances. In these limited instances, the Network benefits will be applied to Non-Network Usual, Customary and Reasonable allowances:

Emergency Care – If a Covered Person requires care for a Medical Emergency (see Definitions) and must use the emergency room of a Non-Network Hospital, then Network benefit levels will be provided for the first 48 hours or until the patient's condition has been stabilized to the point that he could be transferred to Network care. Thereafter, the Covered Person must be transferred to Network provider care or Non-Network benefits will commence.

No Choice of Provider – If a Covered Person receives services or supplies from a Non-Network provider in a situation in which he has no control over provider selection (such as in the selection of an anesthesiologist, assistant surgeon or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Out of Area Services – If a Covered Person requires medical care while outside of the Network service area and treatment cannot reasonably be deferred until travel to a Network provider is feasible, then services of Non-Network providers will be covered at the Network benefit levels.

Referrals for Unavailable and Specialized Services or Supplies – If a Covered Person is transferred or referred by a network provider to a Non-Network provider for care which:

- is not of a type provided by any current Network provider and requires the use of advanced or unusual health care expertise, skill or equipment; or
- is an institution, facility, agency or organization (other than a Hospital) of a type that is different than any current Network provider, or is a person holding a health care professional license which is not of the same type as that held by any current Network provider;
- then the Non-Network will be covered at the Network benefit levels.

If you have any questions about whether an expense is a covered expense, or whether it is eligible for accumulation toward your out-of-pocket expense limit, please contact the third party administrator for assistance.

COST CONTAINMENT PROVISIONS

Utilization Review Program for Inpatient Services
Inpatient care is normally the greatest part of the Plan's expenses and can be the most critical part of your treatment. Through the Plan's Utilization Review Program, it is possible to work with your attending physician to arrange for care in a setting that is more comfortable for you, such as your home, and to save both you and the Plan unnecessary expense.

The Program works by establishing a communication among you, your attending physician and the Utilization Review Program administrator to discuss the proposed course of treatment and any options that may be available for your treatment. The role of the Utilization Review Program is to establish the medical necessity for the **setting** of the treatment, not for the treatment itself. The Utilization Review Program does not establish your eligibility for coverage under the Plan, nor does it approve the services for coverage or reimbursement under the Plan. Those responsibilities rest with the Plan Administrator.

Because communication is the basis for the program, the Plan requires that you contact the Utilization Review Program administrator within 48 hours following the inpatient admission. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.**

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notification is still encouraged at the time of admission, and is required for any hospital stay that is in excess of the minimum length of stay. Failure to notify the Pre-authorization Program administrator of any stay that is in excess of the minimum length of stay will result in application of a penalty to the hospital expenses.

Concurrent Inpatient Review
Once the inpatient setting has been reviewed, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your physician, the Utilization Review Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

The Utilization Review Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Inpatient Utilization Review Program administrator for this Plan is:

Anthem/Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007
(800) 274-7767

Penalty for Non-Compliance
If you fail to notify the Utilization Review Program administrator within the time periods described in this section, the benefits that otherwise would be available for the facility's expense under the Plan will be reduced as follows:

The Plan's benefit percentage for the Non-Network facility expenses will reduce to 50%. If pre-service review and authorization is requested and denied but patient is admitted anyway, room and board expenses will not be covered. Ancillary Inpatient services and supplies, however, will be covered at the Plan's normal benefit percentage as shown in the **Medical Benefit Summary**.

No benefits will be provided for any day of Inpatient confinement which is determined to be not Medically Necessary EXCEPT that, if a day of confinement has been authorized and is later determined to have been not Medically Necessary, coverage will be provided but ONLY for the facility's room and board charges.

If the pre-service review requirements are not completed for services of a Home Health Care Agency or a visiting or private duty nurse, the Plan's benefit percentage for any such services will reduce to 50%.

Any additional share of expenses which becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

A review determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

Pre-authorization is required for outpatient Care or any service over $1,000.

Because communication is the basis for the Program, the Plan requires that you contact the Pre-authorization Program administrator at least two days before the commencement of non-emergency services of the types listed in this section. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.**

Urgent or Emergency Care
Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health because of the requirements of this Program. Pre-authorization of outpatient emergency care is not recommended or required under these circumstances.

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

Concurrent Outpatient Review
If the treatment has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your physician, the Pre-authorization Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

The Pre-authorization Program administrator for this Plan is:

Benefit and Risk Management Services (BRMS)
P.O. Box 2140
Folsom, CA 95763-1240
(800) 368-0767

The Pre-authorization Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

Penalty
If you fail to notify the Pre-authorization Program administrator within the time periods described in this section for non-emergency outpatient care, the benefits that otherwise would be available for those services under the Plan will be reduced as follows:

- Covered expenses will be reduced by 50%, and this amount will not accumulate toward any out-of-pocket expense limits.

Any amount of reduction due to a penalty will not accumulate toward any out-of-pocket expense limits under the Plan.

A pre-authorization or concurrent review determination by the Plan under this provision will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

Pre-determination of Medical/Surgical Benefits
As required by the Plan, this service will help you determine, in advance, if a proposed treatment is expected to cost $1,000 or more. **You are required to use this service to avoid incurring non-covered expenses for which you will be responsible.**

In order to evaluate the proposed treatment, the Plan Administrator will require detailed medical information from your physician, including:

- The identity of the patient (including date of birth and sex);
- The diagnosis code (ICD-9);
- The procedure code (CPT); and
- The amount of the proposed charge.

This information should be submitted to:

BRMS Benefit and Risk Management Services
P.O. Box 1697
Folsom, CA 95763-1240
(800) 368-0767

You will receive a written response with the Plan Administrator's determination, which you may furnish to your physician if you so desire.

A pre-determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health in order to pre-determine benefits. Pre-determination of benefits is not recommended under these circumstances.

Since the Plan does not require you or a covered dependent to obtain approval of any surgical procedure prior to getting treatment for an urgent care or emergency situation, there are no "Pre-service Urgent Care Claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment, and file the claim as a "Post-service Claim."

After the procedure for the diagnosis has been determined as medically necessary and therefore a covered benefit, the decision to undergo the proposed surgical procedure is yours alone. The Plan Administrator will not interfere with the proposed treatment or the physician-patient relationship.

Inpatient Case Management Program

In certain circumstances, especially in the case of a very serious illness or injury, the Plan may make available its Case Management Program services to the covered person. This is strictly a voluntary program; no covered person is obligated to participate and benefits will not be adversely affected.

The Inpatient Case Management Program is administered by Anthem/Blue Cross of California. Case managers are medical professionals who will work with your attending physician to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for In-Patient Case Management, you will be contacted by a case manager who will then work with you and your physician throughout the course of treatment. If you have any questions about the Inpatient Case Management Program, please feel free to contact Anthem/Blue Cross at (800) 274-7767.

SCHEDULE OF MEDICAL BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, "Medical Benefits" and "Exclusions and Limitations." You may find the "Definitions" section helpful in understanding some of the italicized terms used throughout this summary plan description. In addition, the Plan has other requirements and provisions that may affect benefits, such as "Cost Containment Provisions," and it is strongly recommended that you read the entire summary plan description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

ANNUAL DEDUCTIBLES	**Network**	**Non-Network**
Individual Deductible	$300	$600
Family Maximum Deductible	$900	$1,800
Retiree Deductible	$300	$600
Retiree Family Maximum Deductible	$900	$1,800

Individual Deductible / Retiree Individual Deductible – The Individual Deductible is an amount which a Covered Person must contribute toward payment of eligible medical expenses. The Deductible usually applies before the Plan begins to provide benefits. The "Annual Deductible" applies to each Plan Year of the District's Plan which will be July 1 – June 30th.

Family Maximum Deductible / Retiree Family Maximum Deductible – If eligible medical expenses equal to the Family Maximum Deductible are incurred collectively by 3 or more family members during a Plan Year (July 1 – June 30th) and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "Family" includes a covered Employee and his covered dependents.

Deductible Carry-Over – Eligible Expenses incurred in the last 3 months of a Plan Year (July 1 – June 30th) and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Plan Year.

IMPORTANT: ANY SERVICE OVER $1,000 WILL REQUIRE PRE-AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

OUT-OF-POCKET MAXIMUMS	Network	Non-Network
Individual Out-Of-Pocket Maximum	$2,500	$5,000
Family Out-Of-Pocket Maximum	$6,250	$12,500

Individual Out-Of-Pocket Maximum – Except as noted, a Covered Person will not be required to pay more than $5,000 (or $2,500 for Network services and supplies) in a Plan Year (July 1 – June 30th) toward Eligible Expenses which are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Plan Year (July 1 – June 30th).

Family Out-Of-Pocket Maximum – Except as noted, a Covered family (Employee and his Dependents) will not be required to pay more than $12,500 (or $6,250 for Network services and supplies) in a Plan Year (July 1 – June 30th) toward Eligible Expenses which are not paid by the Plan. Once the family has paid their out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Plan Year (July 1 – June 30th)

NOTE: Out-Of-Pocket expenses that count toward the maximum include deductible, co-pays and coinsurance. The Out-Of-Pocket does not apply to or include expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.

WARNING: The Out-Of-Pocket maximum does not apply to expenses which exceed the Plan's limits or which are not covered. For instance, the Plan will never pay benefits for expenses which are in excess of Usual, Customary and Reasonable. The Non-Network out-of-pockets are the maximum out-of-pockets that will be required. For Network providers, however, only the lesser maximums will apply.

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Birthing Center & Related Physician Services	80%	60%
Chiropractic Care, per Visit Limited to 30 visits per Plan Year	$20 Co-Pay*	Not Covered
Diagnostic Lab & X-Ray, Outpatient Pre-Operative Testing, see NOTE Other Outpatient Diagnostic Services	100% 80%	100% 60%

NOTE: "Pre-operative testing' means diagnostic services provided prior to a scheduled Hospital admission when:

the tests are related to the scheduled surgery;

the tests are done within 7 days prior to the scheduled surgery;

the person undergoes the scheduled surgery in a Hospital or Ambulatory Surgical Center (unless the tests show that it should not be done because of the patient's physical condition);

the surgery is a procedure which is covered by the Plan;

the test results appear in the person's medical records kept by the Hospital or Ambulatory Surgical Center in which the surgery is to be done; and

the tests are not repeated in or by the Hospital or Ambulatory Surgical Center where the surgery is done.

IMPORTANT: ANY SERVICE OVER $1,000 WILL REQUIRE PRE-AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

A pre-determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Home Health Care	80%	60%
Limited to 100 visits per Plan Year. Each visit by a nurse, social worker, nutritionist or by a therapist and each visit of up to 4 hours of home health aide services will count as 1 visit.		
Hospital Services		
Inpatient Care, per admission	80%	60%
Emergency Room:		
In a Medical Emergency, per use - See NOTE 1	$150 Co-Pay, then 80%	$150 Co-Pay, then 60%
In a non-emergency	Not Covered	Not Covered
Other Outpatient Services & Supplies – see NOTE 2	80%	60%
NOTE 1: The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room. See "Medical Emergency" in the Definitions section. NOTE 2: See "Outpatient Surgery" below.		
Mental Health Care		
Inpatient Care, per admission	80%	60%
Outpatient Visits	$20 Co-Pay *	60%
Outpatient Surgery (facility & professional care)	80% *	60% *
Physician Services (except mental health/substance abuse)		
Inpatient Visits	80%	60%
Office Visits, per visit (non-surgical) – see NOTE	$20 Co-Pay *	60%
Other Services – see NOTE	80%	60%
NOTE: An office visit includes all non-surgical services performed at the time of the office visit. Also see "Outpatient Surgery" above.		

IMPORTANT: ANY SERVICE OVER $1,000 WILL REQUIRE PRE-AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

A pre-determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Preventive Care Physical Exam Preventive Care includes: Routine physical exams and any of the following when performed in conjunction with and done or ordered at the time of an exam; a GYN exam, laboratory work, X-rays, immunizations and tuberculosis testing. For a child under age 18, a routine physical exam will also include a hearing exam and an eye exam to determine the need for any hearing or vision correction. Coverage for physical exams is limited to the following age and frequency schedule: Age — Allowance or Frequency Birth to age 1 — 6 exams Age 1 to age 2 — 3 exams Age 2 to age 4 — 3 exams Age 4 to age 6 — 1 exam per year Age 6 and over — 1 exam every 2 Plan Years, or as recommended by the patient's Physician Mammograms for breast cancer screening at frequencies and ages shown below: - a baseline mammogram for women ages 35 to 39, inclusive - a mammogram for women age 40 to 49, inclusive, every two Plan Years - a mammogram every year for women age 50 and over 1 routine Pap smear every Plan Year 1 routine eye exam every 2 Plan Years 1 routine PSA test for men every Plan Year **See Definition of Essential Benefits in the Definition Section	100%	Not Covered
Second (& 3rd) Surgical Opinion (if recommended by Utilization Management)	100% *	100% *
Short-Term Rehabilitation, per visit (occupational, physical & speech therapy) Limited to 60 visits/occurrences per Plan Year	$20 Co-Pay*	60%
Skilled Nursing Facility / Rehabilitation Center	80%	60%
Limited to 120 days per convalescent period. A "convalescent period" ends when the Covered Person has not been confined in a Hospital, Skilled Nursing Facility or Rehabilitation Center, or other place giving nursing care for 90 days in a row.		
Substance Abuse Care Inpatient Care, per admission Outpatient Visits	 80% $20 Co-Pay *	 60% 60%
All Other Eligible Medical Expenses	80%	60%

****Plan Year Deductible does not apply***

IMPORTANT: ANY SERVICE OVER $1,000 WILL REQUIRE PRE-AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

A pre-determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

ABOUT THE SUMMARY…

The percentages shown in the summary reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been deducted. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates and not necessarily to the provider's actual charges or the usual charges of similar providers. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

A "Co-Pay" is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

PRESCRIPTION DRUGS, OUTPATIENT

Prescription Drug Card Program	
Retail Purchase	Co-pay/Deductible
Prescription Drug Card Program — Generic and OTC Drugs – see Note	$ 5.00
Prescription Drug Card Program — Brand Name – Formulary Brand-Name Drug	$25.00
Prescription Drug Card Program — Brand Name – Non-formulary Brand-Name Drug	$40.00
Prescription Drug Card Program — Specialty	$250.00 deductible/ $60.00
Mail-Order Option	
Prescription Drug Card Program — Generic – see Note	$10.00
Prescription Drug Card Program — Formulary Brand-Name Drug	$50.00
Prescription Drug Card Program — Non-formulary Brand-Name Drug	$80.00

Benefits are provided for the purchase of drugs through the Plan's Prescription Drug Card Program. The covered person must purchase the prescription drugs through the Prescription Drug Card Program, and use either a participating pharmacy or the "mail order option." To use the program, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 30-day supply for the Co-Pays shown.

The program also includes a "mail-order" option for maintenance (longer term) drugs. Mail-order drugs are available in up to a 90-day (or 30-day for any medication classified as a controlled substance) supply for the Co-Pays shown.

A prescription will be filled with a generic drug unless a brand-name drug is specified by the Physician. If an individual prefers a brand-name drug and there is no medical necessity for its use over a generic drug, the Covered Person will be required to pay the brand-name Co-Pay plus the difference in price between the brand-name drug and its generic equivalent.

Specialty Prescription Drug

Specialty Prescription Drug coverage is subject to a separate deductible of $250. After the deductible is satisfied, the Covered Person shall pay a $60 co-pay. All Prescription Specialty Drugs must be filled through our specialty pharmacy. Please see the directory on page 2 for the specialty pharmacy information. A list of covered and excluded drugs is available from the Pharmacy Benefit Manager (PBM).

NOTE: OTC (over-the-counter) drugs are those recommended by the PBM (i.e., Prilosec OTC and Claritin).

Prescription drugs that are not purchased through the Plan's Prescription Drug Card Program will not be covered expenses and are not eligible for reimbursement.

The Plan's Prescription Drug Card Program is administered by American Health Care. American Health Care has a network of pharmacies which can identify covered persons and the Plan's coverage provisions. To find out which pharmacies participate, contact American Health Care at (800) 872-8276.

Covered Prescriptions
Under the Prescription Drug Card Program, covered expenses include:

- **Anorexiants.** (weight control drugs).
- **Diabetes**. Syringes and needles used only to inject insulin.
- **Insulin.**
- **Legend drugs.** Federal legend drugs.
- **Oral contraceptives.**
- **Retin A.**
- **State-restricted.**

Certain drugs are not covered, even when prescribed by your physician. Please refer to the list of "Excluded Drugs" below.

How the Program Works
There are two ways to purchase drugs through the Plan's Prescription Drug Card Program. You may save money by using the "mail order option" if you have prescription drug(s) that you must take on an on-going basis.

- To fill a prescription at a participating pharmacy (the "pharmacy option"), simply present your Plan ID card and pay your portion of the cost (shown in the "Schedule of Benefits"). The pharmacist will file the claim for you.
- To fill a prescription through the Drug Card Program's "mail order option":
  - Obtain a copy of the mail order form from www.americanhealthcare.com.
  - Complete the patient profile questionnaire (for your first order only).
  - Ask your physician to prescribe the needed medication for a 90-day supply, plus refills.
  - If you are presently taking medication, you will need a new prescription.
  - If you need the medication immediately, **but will be taking it on an on-going basis,** ask your physician for two prescriptions: one for a 14-day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the "mail order option."
  - Send the completed patient profile questionnaire to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost (shown in the "Schedule of Benefits").

Once your order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.
Copayments for the Prescription Drug Card Program do not accumulate toward the out-of-pocket expense limit.

Excluded Drugs
The Plan will not cover the following drugs under the drug prescription plan, even when prescribed by the covered person's physician:

- Contraceptives implants (Norplant) and IUDs
- Cosmetic Only Indications – photo-aged skin products (Renova), injectable Cosmetics (Botox), Hair Growth Agents (Propecia, Vaniqa)
- Dermatology – Depigmentation products used for skin conditions requiring a bleaching agent. Accutane and Sporanox are covered if pre-authorized
- Experimental or investigational drugs, including compounded medications for non-FDA-approved use
- Drugs which are not medically necessary for the treatment of an illness, injury or pregnancy
- Impotence injectables (Caverject, Edex) and Yohimbine (not FDA approved for this indication)
- Infertility or Fertility Drugs
- Serums, Toxoids, Vaccines
- Smoking Cessation Products
- Non-Legend Medications (OTC)
- Gardasil
- Diabetic Supplies such as blood glucose calibration solutions, urine tests, lancet devices
- Fluoride
- Growth hormones. Growth hormones, if pre-approved
- Non-legend drugs, other than insulin
- Norplant
- Provided in or through a Physician's office (drugs intended for use in a setting other than the physician's office)
- Rogaine
- Smoking cessation products
- Therapeutic devices or appliances, support garments, and other non-medical substances
- Vitamins, except prenatal
- Workers' Compensation: prescriptions which an eligible person is entitled to receive, without charge, under any workers' compensation law, or under any municipal, state or federal program

ELIGIBLE MEDICAL BENEFITS

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (application of Deductible requirements and benefit sharing percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and which are incurred by a Covered Person – subject to the **Definitions, Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition. "Medically Necessary" means services and supplies which are:

- reasonably required for the treatment or management of the health disorder;
- commonly and customarily recognized by Physicians as appropriate in the treatment or management of the health condition;
- other than educational, experimental or custodial in nature.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree of frequency of services and treatment which can be provided ONLY on an Inpatient basis.

For benefit purposes, medical expenses will be deemed to be incurred on:

- the date a purchase is contracted; or
- the actual date a service is rendered.

Please refer to the "Cost Containment Provisions" section for important information concerning any requirements of the Plan for prior approval of certain services. The following covered expenses must be incurred while coverage is in force under this Plan. Reimbursement will be made according to the "Schedule of Benefits," and will be subject to all Plan maximums, limitations, exclusions and other provisions.

Abortion
See "Pregnancy Care"

Acupuncture
The only time acupuncture is covered is when it is performed by a Physician and used as a form of anesthesia in connection with surgery that is covered under the Plan.

Alcoholism
See "Substance Abuse Care"

Ambulance Service
Professional ambulance service when used to transport the Covered Person from the place where he is injured or stricken by a Sickness to the first Hospital where treatment is given, and for Medically Necessary transportation between medical facilities.

Air ambulance services will be covered when medically necessary to transport the covered person to the nearest institution capable of treating the illness or injury.

Ambulatory Surgical Center
Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia Services

Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia. Covered expenses include the administration of spinal, rectal or local anesthesia, or a drug or other anesthetic agent by injection or inhalation, rendered by a licensed provider. Covered expenses do not include anesthesia administered by the surgeon physician.

Allergy Care

Benefits are provided for allergy care, including injections, serums and extracts, given in a physician's office. Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

Birthing Center

Services and supplies provided by a Birthing Center (see **Definitions**) in connections with a covered Pregnancy.

Blood Transfusions and Blood Products, to the extent not replaced.

Blood and blood plasma (if not replaced), including blood processing and administration services. The Plan will also cover processing, storage and administration charges when a Covered Person self-donates his own blood in anticipation of an elective surgery which can reasonably be expected to require blood.

Cardiac Rehabilitation

Benefits are provided for cardiac rehabilitation program services when certified as medically necessary by the attending physician in a treatment program that is appropriate for the covered person's illness.

Chemical Dependency

See "Substance Abuse Care".

Chemotherapy Services

Benefits are provided for administration of chemotherapy treatment, including the usual, customary and reasonable fee for drugs and supplies used during the treatment.

Chiropractic Care Services

Covered expenses include spinal manipulation, X-rays, and other related therapy treatments to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Clinical Trials

Certain items in connection with clinical trials for certain individuals are required to be covered, but it does not require coverage of the item being investigated in the clinical trial. Clinical trials generally are studies that test new drugs, procedures or devices on humans. To be subject to the requirements, a clinical trial must be a phase I through phase IV clinical trial that is being conducted in connection with the prevention, detection or treatment of cancer, or other life-threatening disease or condition and is:

- Federally funded through a variety of entities or departments of the federal government
- OR conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration
- OR exempt from investigational new drug application requirements

To qualify for coverage in connection with a clinical trial, a participant or beneficiary must be eligible, according to the clinical trials protocol, to participate in a clinical trial meeting the criteria noted above for the treatment of cancer or other life-threatening disease or condition (which is likely to result in death unless the disease or condition is interrupted). In addition either:

- The referring health care professional is a participating provider and has concluded that the participant's or beneficiary's participation in the clinical trial would be appropriate

- OR the participant or beneficiary provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

For qualifying individuals and clinical trials, group health plans may not deny participation in a clinical trial, deny (or otherwise limit or impose additional condition on) coverage of routine patient costs for items and services furnished in connection with the clinical trial, or discriminate against the individual based on participation in the trial. Routine patient costs relate to items and services typically provided under the plan for a participant not enrolled in a clinical trial. In other words, if certain items and services are typically covered under the plan, the plan must cover them when the items and services are provided to a participant in an approved clinical trial. Such items and services not included are:

- The investigational item, device or service itself
- Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis
- Any service clearly not consistent with widely accepted and established standards of care for the particular diagnosis

The Plan will require a qualifying individual to use an in-network provider participating in a clinical trial if the provider will accept the individual as a participant. However, the requirements also apply to participation in a clinical trial conducted outside the state of the individual's residence if the Plan provides out-of-network coverage for routine patient costs. BRMS Managed Care Department must review and approve for medical necessity and make sure all requirements have been met before the trial may begin.

Diagnostic X-ray and Laboratory Services

Benefits are provided for diagnostic x-ray and laboratory services given in a physician's office which are required for the diagnosis or treatment of an illness or injury. Covered services include the scanning and imaging work (e.g. CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis Services and Supplies

Benefits are provided for kidney dialysis treatment, including the usual, customary and reasonable fee for drugs and supplies used during the treatment. Coverage also includes outpatient maintenance home dialysis, dialysis supplies, and home dialysis training. Once you are diagnosed with end stage renal disease you must enroll in Medicare to receive plan benefits. Upon beginning dialysis treatments, Medicare will coordinate benefits with the Plan as the secondary payor for months 4 through 33 of the coordination period while you are receiving dialysis treatments. As of the July 1, 2012, your dialysis benefits will be covered and paid above the Medicare payment levels. Your dialysis medical claims will be re-priced and paid at 125% Medicare's reimbursement level. The Plan will not enroll you in Medicare; it is your decision and your responsibility to enroll in Medicare.

In order for us to coordinate your plan benefits with Medicare coverage, we are hereby requiring you to follow the following steps:

1. Notify BRMS when you are diagnosed with ESRD by your doctor, and
2. Notify BRMS if or when you begin to receive dialysis treatments.

Durable Medical Equipment

Covered expenses include rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted – which is prescribed by a Physician and required for temporary (generally for a period not to exceed six months) therapeutic use in treatment of an active Sickness or Accidental Injury.

Repair or replacement of durable medical equipment and accessories, except that replacement is covered ONLY if the Plan Sponsor is shown that:

- It is necessary due to a change in the physical condition of the Covered Person; or
- It is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment
- Durable medical equipment includes such items as orthotics (including foot orthotics), braces, crutches, wheelchairs, hospital beds, dialysis equipment, etc. which (a) can withstand repeated use, (b) are primarily and customarily used to serve a medical purpose, (c) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (d) are appropriate for use in the home. It does not include items for use in altering air quality or temperature or for exercising or training

Eyeglasses, contact lenses in coordination with cataract surgery

For eyeglasses, contact lenses and refractions, or the examination for their prescription and fitting, except one pair of lenses following surgery for cataracts. See Schedule of Medical Benefits.

Home Health Care

Covered expenses include home health services when rendered by a licensed and accredited home health care agency. These services must be provided through a formal, written home health care treatment plan, certified as medically necessary by the attending physician, and approved by the Plan. The attending Physician must certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the home health care plan. Benefits are provided for:

- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family
- Physical, occupational, and speech therapy
- Services provided by a licensed social worker (M.S.W.)
- Services provided by a home health aide

On-going home health services will require re-certification by the attending physician and approval by the Plan, at the Plan Administrator's discretion, in order to qualify for continued coverage.

The total benefits paid for home health care on a weekly basis may not exceed the amount the Plan would have paid if the covered person had been confined in a hospital, skilled nursing facility or other institution.

NOTE: Covered home health care expenses will not include services and supplies which are not part of the home health care plan, services of a social worker, or transportation.

Hospice Care

Covered expenses include hospice care services for a terminally ill covered person when provided by a hospice care agency. The services must be provided through a formal, written hospice care treatment program and certified by the attending physician as medically necessary. Benefits are provided for:

- Room and board for confinement in a licensed, accredited hospice facility
- Services and supplies furnished by the hospice while the patient is confined
- Part-time nursing care by or under the supervision of a registered nurse
- Nutrition services and/or special meals

- Respite services

- Counseling services by a licensed social worker or a licensed counselor

- Bereavement counseling by a licensed social worker or a licensed counselor for the employee and/or covered dependent(s)

The attending physician must certify that the covered person is expected to continue to live for six months or less in order to qualify for this benefit

If the covered person lives beyond six months, the Plan will approve additional hospice care benefits on receipt of satisfactory evidence of the continued medical necessity of the services

Hospital Emergency Room Services

Covered expenses include:

- Emergency treatment of an accidental injury
- Emergency treatment of an illness

Covered expenses also include physician's charges, and charges for radiology and pathology, for emergency surgical or medical care rendered in the hospital emergency room

The diagnosis for an Emergency room visit must be considered a medical emergency (see "Medical Emergency" in the Definitions section) or it is not covered

A true medical emergency is generally a serious medical condition or symptom (including severe pain) resulting from injury, sickness or mental illness which arises suddenly and requires immediate care and treatment (generally received within 24 hours of onset) to avoid jeopardy to the life and health of the person

Some examples of medical emergencies include:

- Uncontrolled bleeding
- Loss of consciousness or seizure
- Severe shortness of breath
- Chest pain
- Poisoning
- Suspected overdose of medication
- Sudden onset of paralysis or slurred speech
- Severe burns or cuts
- Inability to swallow

Hospital Inpatient Care

For medical or surgical care of an illness or injury, the Plan will reimburse covered expenses for semi-private room and board and necessary ancillary expenses. If the hospital does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other hospitals in that geographic area.

Covered expenses will include cardiac care units and intensive care units, when appropriate for the covered person's illness or injury.

In-Hospital Concurrent Medical Care

Covered expenses include services rendered concurrently by a physician other than the attending physician when the covered person is being treated for multiple, unrelated illnesses or injuries, or which require the skills of a physician specialist.

In-Hospital Consultant Services

Covered expenses include the services of a physician consultant when required for the diagnosis or treatment of an illness or injury.

In-Hospital Medical Services

Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

Infertility Testing and Treatment

Diagnostic procedures necessary to determine the cause of infertility and medical and surgical treatment of the underlying causes of the infertility.

Injections

Benefits are provided for therapeutic injections given in a physician's office which are required for the treatment of an illness or injury. Immunizations and other injections which are not for the treatment of an illness or injury are not covered unless specified under "Preventive Care." Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

Intravenous Therapy

Benefits are provided for administration of intravenous therapy, including the usual, customary and reasonable fee for drugs and supplies used during the treatment.

Lenses

Benefits are provided for one set of lenses (contact or frame-type) following surgery for cataracts.

Maternity Care – see also "Pregnancy Care"

Dependent children are not eligible for coverage for any expenses in connection with pregnancy. Coverage may be available for expenses related to certain complications of pregnancy.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are payable in the same manner as for medical or surgical care of an illness, shown in the "Schedule of Benefits" and this section, and subject to the same maximums.

Medical Emergency

An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a Pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part. A Medical Emergency can include but is not limited to:

- Sudden onset of severe chest or abdominal pain
- Seizures or convulsions
- Poisonings or an overdose of drugs
- Loss of consciousness
- Sudden or severe difficulty in breathing
- Prolonged or severe bleeding from any site
- Serious traumatic injuries such as knife or gunshot wounds, rape, broken bones, severe burns, eye injuries, suicide attempts or poisonous bites

Medical Supplies

Medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

Medicines

Medicines which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. See "Prescription Drugs, Outpatient" in the **Medical Benefit Summary** for Outpatient prescription coverage information.

Mental or Nervous Disorder In-Hospital Medical Care Services

Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

Mental or Nervous Disorder Inpatient and Partial Hospitalization

Covered expenses for inpatient care of a mental or nervous disorder include semi-private room and board and necessary ancillary charges. Treatment must be rendered in a hospital or psychiatric treatment facility. If the hospital or psychiatric treatment facility does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other hospitals in that geographic area.

For Plan purposes, a "mental health condition" is a condition which is commonly understood to be a mental or nervous disorder, whether or not it has a physiological, congenital or organic basis and for which treatment is generally provided by, or under the direction of, a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental health condition will include schizophrenia, bipolar disorder, pervasive mental developmental disorder (autism), panic disorder, major depressive disorder, psychotic depression, or obsessive compulsive. A mental health condition or mental health care will not include:

- childhood learning and behavior disorders including attention deficit disorder, hyperkinetic syndrome, or mental retardation;
- hypnotherapy;
- marriage and family counseling;
- sex counseling or sex therapy;
- vocational testing or training

Midwife

Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy. See "Pregnancy Care" below.

Newborn Care

Coverage for a newborn child will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section.

Covered expenses for newborn children include nursery and neo-natal intensive care room and board, necessary ancillary expenses, and routine newborn care during the period of hospital confinement, including circumcision. Hospital and Physician services provided during the birth confinement to a covered newborn child. If the newborn is not a covered child, then certain Hospital expenses will be covered as part of the mother's Pregnancy claim for delivery, if Plan benefits are payable for such Pregnancy delivery, see "Pregnancy Care" for more information.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Hospital stay for a newborn (birth confinement) to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean delivery. Also, the Utilization Management Program requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

Nursing Services

Services of a registered nurse (RN), licensed practitioner (LPN), nursing agency for visiting nursing care (a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks), or private duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

NOTE: The Plan will not cover services which do not require the skills of an RN or LPN or any nursing care provided while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

Obstetrical Services

Dependent children are not eligible for coverage for any expenses in connection with pregnancy. Coverage may be available for expenses related to certain complications of pregnancy.

Covered expenses include obstetrical services rendered by the physician in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the Plan provisions in effect on the date the services are rendered.

Occupational Therapy

Benefits are provided for occupation therapy to restore a covered person to health, or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore, develop, and maintain the covered person's ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending physician as part of a treatment plan that is appropriate for the covered person's illness or injury. See "Short Term Rehabilitation".

Office Visits

Benefits are provided for services given in a physician's office which are required for the diagnosis or treatment of an illness or injury. Covered services include the services of a physician's assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

Oral Surgical Procedures, including:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth
- Emergency repair due to injury to sound natural teeth
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth
- Excision of benign bony growths of the jaw and hard palate
- External incision and drainage of cellulitis
- Incision of sensory sinuses, salivary glands or ducts

Outpatient Diagnostic Examinations

Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an illness or injury.

Outpatient Mental or Nervous Disorder Care

Covered expenses include outpatient mental or nervous disorder care by a licensed psychologist, psychiatrist, or social worker, if the social worker services are under the direct supervision of a physician.

Outpatient Substance Abuse Care

Covered expenses include outpatient substance abuse care by a licensed provider.

Outpatient Surgery/Ambulatory Surgery Center

Benefits are provided for charges by a hospital, ambulatory surgical center, or in a physician's office, for services required for a surgical procedure. The facility fees may include both services and supplies required for the surgery.

Oxygen – **see "Durable Medical Equipment"**

Pain Management

Services and supplies provided in accordance with an intensive program that is administered on an Inpatient or Outpatient basis by qualified health care professionals and facilities and under the orders of the patient's attending Physician. Such care must be provided to a Covered Person who is suffering chronic, intractable pain that has failed to respond to medical or surgical treatment.

For these purposes and in addition to appropriate Covered Providers as defined (see Definitions), "qualified health care professionals and facilities" with regard to a pain managements program will include any of the following when: (1) licensed to perform such services and acting within the scope of that license; or (2) in the absence of licensing requirements, certified by the appropriate regulatory agency or professional association:

- acupuncturists (CA)
- pain control centers
- massage therapists

Covered supplies and products include, but are not limited to:

- drugs prescribed or administered by qualified health professional or facilities as part of the pain management program and that are not otherwise available through the Plan's coverage for prescription drugs
- electronic nerve and muscle stimulators (TENS devices, micro current stimulators, galvanic stimulators) and related supplies (e.g. gels)
- heating pads and ice packs
- water pillows

Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following illness, injury or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the illness or injury, and which is ordered by the attending physician.

NOTE: Services provided by the LA Pain Clinic are not covered.

Physical Therapy

Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following illness, injury or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the illness or injury, and which is ordered by the attending physician. See "Short Term Rehabilitation".

Physician Services

Medical and surgical treatment by a Physician (MD or OD), including office, home or Hospital visits, clinical care and consultations. See "Second (&3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

Pre-Admission Testing

Benefits are provided for pre-admission testing for expenses incurred within 14 days prior to the scheduled hospital admission, and only when the testing is not duplicated on admission.

Pregnancy Care

Pregnancy-related expenses of a covered Employee or covered Dependent spouse. Eligible Pregnancy-related expenses include the following, are covered provided at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician;

- Pre-natal visits and routine pre-natal and post-partum care
- Expenses associated with a normal or cesarean delivery
- An elective or non-elective abortion procedure and any complications arising out of an abortion
- Newborn Hospital expenses incurred during the mother's confinement for delivery, subject to the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the Utilization Management Program requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

"Complications of pregnancy" will be covered as any other Sickness and will be covered with regard to an Employee, spouse or a Dependent child. "Complications of pregnancy: include conditions which require Hospital confinement (when the pregnancy is not terminated) and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as:

- An ectopic pregnancy
- A complication requiring intra-abdominal surgery after termination of pregnancy
- Pernicious vomiting of pregnancy (hyperemesis gravidarum)
- Toxemia with convulsions (eclampsia of pregnancy)
- Caesarean section
- Termination of pregnancy occurring during a period of gestation in which a viable birth is not possible
- Any condition requiring Hospital confinement, prior to termination of pregnancy, the diagnosis of which is distinct from pregnancy but is adversely affected by pregnancy or caused by it, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and any similar medical and surgical condition of comparable severity, but excluding false labor, occasional spotting, physician-prescribed rest, morning sickness, pre-eclampsia, and any similar condition associated with the management of a difficult pregnancy not constituting a nosologicalaly distinct complication of pregnancy
- A pregnancy which terminates in any manner other than a normal deliver

NOTE: Pregnancy coverage will <u>not</u> include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother.

<u>Prescription Drugs</u>

Drugs and medicines which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit.

Coverage for other Outpatient drugs (i.e., pharmacy purchases) is provided through a separate program. See the **Medical Benefit Summary** and **Prescription Drug Benefits** for additional information.

Preventive Care Benefit – dependents under the age of 18

Covered expenses include these listed services for preventive care for each covered person, subject to any limits described in the "Schedule of Benefits" section.

- Routine physical exams with the following frequencies:

Birth to age 1	6 exams
Age 1 to age 2	3 exams
Age 2 to age 4	3 exams
Age 4 to age 6	1 exam per year
Age 6 to age 18	1 exam every two (2) Plan Years or as recommended by the patient's physician;

- Immunizations (excluding Gardasil)
- Pap Test
- Preventive Laboratory Screenings
- General Medical Examinations by Physician
- Eye Examinations
- Hearing Examinations
- Preventive X-rays
- Tuberculosis Testing
- Well Child Care

Preventive Care Benefit – adults over the age of 18

Covered expenses include these listed services for preventive care for each covered person, subject to any limits described in the "Schedule of Benefits" section.

- Gynecology Examination
- Immunizations (excluding Gardasil)
- Mammogram Tests with the following frequencies

  A baseline mammogram for women ages 35 to 39, inclusive

  A mammogram for women ages 40 to 49, inclusive, every two (2) Plan Years

  A mammogram every year for women age 50 and over
- Pap Test, limited to one (1) every Plan Year
- Preventive Laboratory Screenings
- General Medical Examinations by Physician
- Eye Examinations, limited to 1 routine exam every 2 Plan Years
- Preventive X-rays
- Prostate Exam, limited to one (1) every Plan Year
- Tuberculosis Testing

Professional Interpretation Services, Inpatient and Outpatient

Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an illness or injury, unless otherwise provided under "Preventive Care."

Prosthetic Devices and Supplies

Including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the covered person's physical structure and the current device cannot be made serviceable.

NOTE: Prosthetics coverage does not include replacement, repair or maintenance of prosthetic devices, other than replacement necessitated by the natural growth process of a child.

Radiation Therapy

Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the usual, customary and reasonable fee for materials.

Reconstruction of a Breast

Following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a mastectomy, including lymphademas, in a manner determined in consultation with the attending physician and the covered person. Reimbursement will be made according to the "Schedule of Benefits" section by type of service.

Rehabilitation Facilities Benefits

Covered expenses for inpatient rehabilitation facilities include semi-private room and board accommodations and necessary ancillary charges. The confinement must begin following an inpatient stay of at least three days in a hospital and must be for continued treatment of the illness or injury being treated in the hospital.

No coverage is provided under this Plan for any expenses incurred by or on behalf of the donor.

Respiratory Therapy

Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

R.N. and L.P.N.

Private duty nursing services for outpatient care when medically necessary.

Second (and 3rd) Surgical Opinions

Covered expenses include a second (& 3rd) opinion to determine the medical necessity for a recommended surgical procedure. The physician rendering the second opinion must not be affiliated with the physician who recommended the surgical procedure. A third opinion will be covered if the two opinions differ, and if it is performed by a physician who is not affiliated with the physicians who have rendered opinions. The surgical opinion consultation must be rendered prior to surgery and within one (1) month of the surgeon's recommendation for surgery. Eligible expenses include necessary lab and radiology services and charges for a written report.

Short-Term Rehabilitation

Outpatient services of a Physician or a licensed or certified physical, occupational or speech therapist for treatment of an acute condition. The therapy must be expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, a disease, or a congenital defect.

Skilled Nursing (or Extended Care) Facilities Benefits

Covered expenses for inpatient skilled nursing or (extended care) facilities include semi-private room and board accommodations, and necessary ancillary charges. The confinement must begin following an inpatient stay of at least three days in a hospital, must be for continued treatment of the illness or injury being treated in the hospital and commencing within fourteen (14) days of discharge from such prior confinement.

NOTE: Coverage is not provided for confinement for treatment of drug additional, chronic brain syndrome, alcoholism, senility, mental retardation or any other mental disorder.

Speech Therapy

Benefits are provided for the evaluation and treatment of covered persons who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the illness or injury, and which is ordered by the attending physician. See "Short-Term Rehabilitation".

Sterilization Procedures

A surgical procedure for the purpose of sterilization (i.e. a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Substance Abuse In-Hospital Medical Care Services

Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Substance Abuse Inpatient and Partial Hospitalization

Covered expenses for inpatient care of substance abuse include semi-private room and board and necessary ancillary charges. Treatment must be rendered in a hospital or substance abuse treatment facility. If the hospital or substance abuse treatment facility does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other hospitals in that geographic area.

Surgical Assistants

Covered expenses include services by a licensed physician who actively assists the operating surgeon in the performance of surgical procedures when the condition of the patient and complexity of the surgery warrant such assistance. Benefits are also provided for these services when rendered by a licensed surgical physician's assistant. Coverage will be provided for these services only when rendered on an inpatient basis, and only when the hospital does not employ interns and residents qualified to perform the service.

Surgical Dressings, Splints, Casts and Other Devices

Used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an illness or injury.

Surgical Services

Covered expenses include surgical procedures, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one surgical procedure is performed during the same operative session, the allowed expense is calculated as follows:

- 100% of the covered expense, after any PPO network provider discount, for the most complex procedure
- 50% of the covered expense, after any PPO network provider discount, for the second procedure
- 25% of the covered expense for each subsequent procedure
- No benefit is payable for incidental procedures (such as an appendectomy during abdominal surgery)

Temporomandibular Joint Dysfunction (TMJ)

See "Dental Care" in the Medical Limitations and Exclusions section.

Transplants

Organ transplants which are recognized for reimbursement by Medicare, such as kidney and cornea, when the Covered Person is the transplant recipient.

Expenses of a Covered Person who is an organ or bone marrow donor will be covered to the extent that the expenses are:

- directly related to the determination of organ acceptability; and
- directly related to securing and implanting the organ.

The Plan Administrator strongly recommends that any covered person who is a candidate for any transplant procedure contact Blue Cross before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the Plan, before the actual services are rendered.

In addition, the Plan Administrator has made arrangements with selected providers, called "Centers for Excellence," where a covered person may receive care at a negotiated rate. Using a Center for Excellence will normally result in lower costs to the Plan and the covered person. Please contact Anthem/Blue Cross for additional information about Centers for Excellence.

Covered expenses include the following types of transplants:

Solid Organs

Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This Plan excludes transplantation of non-human organs.

Bone Marrow Transplants

Benefits are provided for medically necessary bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

Finding a donor who is an acceptable match for donation is important to the success of an allogenic/homologous bone marrow transplant. Because an immediate family member has the greatest chance of being a match, benefits for determining bone marrow matching are provided only for members of the immediate family and only if the proposed bone marrow transplantation is medically necessary and is not considered experimental or investigational. For purposes of this section, immediate family members include mother, father, biological children and biological siblings. If a donor match cannot be identified in the immediate family, the Plan will cover matching through a national registry.

Tissue Replacement

Benefits are provided for the replacement of human tissue (with human tissue or prosthetic devices).

Other Benefits Related to Transplantation
Benefits are also provided for:

- The preparation, acquisition, transportation and storage of human organs, bone marrow, or human tissue.
- Transportation of the covered person, if the organ recipient, to and from the site of the transplant procedure.

Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow, or tissue.

- When the transplant recipient and donor are both covered under this Plan, payment for covered expenses is provided for both, subject to each covered person's respective benefit maximums.

- When the transplant recipient is covered under this Plan but the donor is not, payment for covered expenses is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.

- When the transplant recipient is not covered under this Plan but the donor is covered, payment for covered expenses attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.

Urgent Care Facility

See **Definitions**.

MEDICAL EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations – Medical
This Plan will not reimburse any expense that is not a covered expense. This Plan does not cover any charge for the following services or supplies:

Air Purification Units: air conditioners, air-purification units, humidifiers and electric heating units

Bioenergetic Therapy

Biofeedback Services: Benefits are not provided for biofeedback as part of a program approved by the Plan Administrator for pain management.

Birth control drugs or devices: For birth control drugs or devices, whether or not dispensed by prescription, that are purchased or prescribed for the sole purpose of preventing conception. **Note:** contraceptive medications are covered by the prescription drug program.

Carbon Dioxide Therapy

Certain exams and Services. For physical examinations and other services that are (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation.

Childhood Disorders – treatment of learning disorders, behavioral problems or hyperkinetic syndrome.

Contraceptive Devices or Medications – medications, devices or the filling of devices for birth control purposes. NOTE: Contraceptive medications are covered through the prescription drug program. See "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**.

Cosmetic & Reconstructive Surgery: 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:

- services necessitated by a non-occupational Accidental Injury, and then limited to Eligible Expenses incurred in the Plan Year in which the accident occurred or the next Plan Year;

- 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 lymph nodes). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

- surgery which is necessary to improve the function of a body part that is not a tooth or structure that supports the teeth, and that is malformed: (1) as a result of a severe birth defect, or (2) as a direct result of disease or surgery performed to treat a disease or injury.

Counseling: For counseling, except as specifically the result of a mental or nervous condition, for:

- Marital difficulties
- Social maladjustment
- Pastoral issues
- Financial Issues
- Behavioral issues
- Lack of discipline or other antisocial action.

Criminal Activities
Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault, felony or misdemeanor, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Custodial Care: For assistance with activities of daily living (i.e., walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Dangerous Activity - An undertaking so dangerous that, even if precautions and reasonable care are used, it cannot be safely performed and anyone who engages in it is strictly liable for any resulting injuries and damage, especially if (1) there is a risk of serious harm to people or property, (2) the activity cannot be performed in some other way that avoids those risks, and (3) the undertaking does not normally occur at the location where it is to take place. (e.g., bungee jumping).

Dental Hospital Admissions: Related to dental hospital admissions, unless determined to be medically necessary because of a concomitant condition.

Dental Care: Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, EXCEPT as follows:

- surgical treatment of a fracture, dislocation or wound
- excision of teeth partly or completely impacted in the bone of the jaw, teeth that will not erupt through the gum, and other teeth that cannot be removed without cutting into bone
- excision of the roots of a tooth without removing the entire tooth
- excision of cysts, tumors, or other diseased tissues
- cutting into the gums and tissues of the mouth when not done in connection with the removal or repair of teeth
- alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- non-surgical treatment of infections or diseases by not including those of or related to the teeth or supporting bone or gum tissue
- dental work, surgery and orthodontic treatment to repair sound natural teeth damages, lost or removed or other body tissues of the mouth fractured or cut due to Accidental Injury. Treatment must be done in the Plan Year of the accident or the next Plan Year. If crowns, dentures, bridgework or in-mouth appliances are used to treat such an injury, only the initial placement will be covered. For these services, "Physician" includes a dentist

Dependent Pregnancy. Dependent children are not eligible for coverage for any expenses in connection with pregnancy unless related to a complication of the pregnancy.

Developmental Delay: For developmental disorders, including learning disabilities, mental retardation or autism.

Diagnostic Hospital Admissions: confinement to a hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Disposable supplies. For home use, such a bandages, gauze, tape, antiseptics, dressings, diapers, underpads and other incontinence supplies.

Ecological or Environmental Testing or Training: chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training: testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation. Treatment of health care providers who specialize in the mental health care field and who received treatment as part of their training in that field. Care to provide a surrounding free from exposure that could worsen a person's disease or injury.

- This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be medically necessary by the Plan.

Excess over Semi-Private Rate: That are in excess of the semi-private room rate, except as otherwise noted.

Experimental Treatment. An experimental or investigational procedure is defined as the use of a service, supply, drug or device not recognized as standard medical care for the condition, disease, illness or injury being treated. Determinations are made after independent review of scientific data. Opinions of experts in a particular field and opinions and assessments of nationally recognized review organizations shall also be considered by the Plan but are not determinative or conclusive. The fact that an experimental/investigational treatment is the only available treatment for a particular medical condition or that the patient has tried other more conventional therapies without success may not necessarily result in coverage. Due to the advances in medical findings, however, exceptions may be made with the submission of supporting documentation.

Excluded Providers and Facilities: That are rendered or provided by the following excluded providers or facilities:

- Hypnotists
- Naturopaths
- Rolfers
- Marriage counselors

Exercise Equipment / Health Clubs: exercising equipment, vibratory equipment, swimming or therapy pool, enrollment in health, athletic or similar clubs.

Eyeglasses, contact lenses, refractions: For eyeglasses, contact lenses and refractions, or the examination for their prescription and fitting, except one pair of lenses following surgery for cataracts. See Vision Care Benefits.

Eye exercises or training and Orthoptics.

- This exclusion does not apply to Aphakic patients.
- This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
- This exclusion does not apply to one pair of lenses following cataract surgery.
- This exclusion does not apply to benefits as noted in the Vision Care Benefits section.

Eye Surgery. For services related to eye surgery or orthokeratologic services for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism.

Food Supplements: Related to food supplements or augmentation, in any form (unless medically necessary to sustain life in a critically ill person).

Foot care services, routine: For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized illness, treatment of weak, strained, flat, unstable or unbalanced feet, foot massage, injury or symptoms involving the foot.

NOTE: This exclusion does not apply to:

- Medically necessary treatment of the feet (i.e., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease); or

- Foot orthotics. See "Durable Medical Equipment" in the list of **Eligible Medical Expenses** for orthotics coverage.

Genetic Testing and/or Counseling: For genetic testing or counseling concerning inherited (genetic) disorders.

Hair Restoration: Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

Hearing Aids: For hearing aids or devices, or the examination for their prescription and fitting.

Holistic or Homeopathic Medicine: services, supplies, drugs, or accommodations provided in connection with holistic or homeopathic treatment.

Hypnotherapy: treatment by hypnotism.

Impotence: sexual dysfunction. For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or drugs pertaining to sexual dysfunction or impotence.

Impregnation: artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian TransferA) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Treatment: For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility drugs, artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, surrogate mother or donor eggs.

Learning & Behavioral Disorders: Testing or treatment for learning or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), or mental retardation.

Maintenance Care: Services or supplies that cannot reasonable be expected to lessen the patient's disability or to enable him to live outside an institution.

Marital Counseling: Counseling for the purpose of resolving marital problems

Massage Therapy: For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered illness or injury, and approved as medically necessary by the Plan Administrator.

Medically unnecessary: That are not medically necessary for the care and treatment of an injury or illness, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.

Never Events. In addition, serious preventable adverse events ("**never events**") will, in no event be covered under the Plan. These never events include:

- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient;
- Wrong surgical procedure performed on a patient;
- Unintentional retention of a foreign object in a patient after surgery or other procedure;
- Inoperative or immediate postoperative death in an ASA Class I patient;
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility or physician/pharmacist;
- Patient death or serious disability associated with the use or function of a device in a patient in which the device is used or functions other than as intended;
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility or physician/pharmacist;
- Infant discharged to the wrong person;
- Patient death or serious disability associated with patient leaving the facility without permission;
- Patient suicide, or attempted suicide resulting in a serious disability, while being cared for in a healthcare facility;
- Patient death or serious disability associated with a medication error (e.g. error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration);
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
- Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy while being cared for in a healthcare facility;
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns;
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;
- Patient death or serious disability due to spinal manipulative therapy;
- Artificial insemination with the wrong donor sperm or wrong egg;
- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility;

- Patient death associated with a fall while being cared for in a healthcare facility;
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility;
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other provider;
- Abduction of patient of any age;
- Sexual assault of a patient within or on the grounds of a healthcare facility; and
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

Nicotine Addiction: nicotine withdrawl programs, facilities, drugs or supplies.

Non-prescription medicines and supplies: drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter and without a licensed Physician's written prescription, except as included in the prescription coverages of the Plan.

Not Medically Necessary / Not Physician Prescribed: any services or supplies which are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician, unless expressly included herein.

Obesity treatment: For the purpose of weight loss.

- This exclusion does not apply to benefits for surgical or non-surgical treatment of morbid obesity under a treatment plan that has been approved by the Plan Administrator with the following criteria:
    - Bariatric Surgery requires Pre-Certification & must be performed at a Blue Cross designated Center of Excellence
    - Documentation of active participation for at least six months in a structured, medically supervised nonsurgical weight reduction program. A comprehensive commercial weight loss program is an acceptable program component, but it must be selected and monitored under the supervision of the healthcare practitioner providing medical oversight. Comprehensive weight loss programs generally address diet, exercise and behavior modification, i.e., Weight Watchers.
    - Documentation from the clinical medical records must indicate that the structured medical supervision meets all of the following criteria:
    - Occur during at least 6 consecutive months;
        i. Include at least three visits for medical supervision, occurring at intervals of no longer than four months apart, i.e., at the start, middle and end of the 6-month weight loss program.
        ii. Be provided by an MD, DO, NP, PA or a registered dietician under the supervision of an MD, DO, NP or PA; and
        iii. Include assessment and counseling concerning weight, diet, exercise, and behavior modification; and
        iv. Demonstrate active member participation and engagement resulting in either weight loss or no further weight gain by the end of the six month program.
- Evaluation by a licensed psychologist or psychiatrist documents the absence of significant psychopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations (i.e., active substance abuse, eating disorders, schizophrenia, borderline personality disorder, uncontrolled depression);

- Age greater than or equal to 18 years.

Oral Nutrition: For outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas and food.

Orthognathic surgery: (jaw realignment surgery) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.

Pain Management: Services provided by the LA Pain Clinic are not covered.

Personal Comfort or Patient convenience: Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an illness or injury that are solely for the personal comfort and convenience of the patient.

Personal hygiene: For personal hygiene or convenience items.

Pregnancy coverage will not include: 1) Lamaze and other charges for education related to pre-natal care and birthing procedures, 2) adoption expenses, or 3) expenses of a surrogate mother.

Pregnancy of a dependent child: Related to the Pregnancy of a dependent child, including pre-natal, delivery and post-natal care, treatment of miscarriage. This exclusion will not apply to complications of pregnancy.

Prenatal vitamins: For prenatal vitamins.

Preventive or Routine Care: routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, **except as may be specifically included** in the list of **Eligible Medical Expenses.**

Residential Care Facility: Provided by or at a residential care facility or halfway house.

Self-Procured Services: services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Services not approved by the FDA. For drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA.

Sex-related Disorders: Transexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies that do not have a physiological or organic basis. Excluded services and supplies include but are not limited to: Expenses for all services and supplies in connection with sex change operations or procedures.

Smoking cessation: For smoking cessation programs, nicorette gum, nicotine transdermal patches or other treatment of tobacco dependency.

Therapy: That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.

Travel: For travel, even though prescribed by a physician. This exclusion may not apply to a covered person who is an organ transplant recipient to travel to and from the site of the transplant.

Trusses, corsets and other support devices.

Vision Care: vision services and supplies (exams, glasses, contacts, etc.) except for:

routine eye exams as shown in "Preventive Care" in the Medical Benefit Summary; and

the initial purchase of glasses or contact lenses following cataract surgery

Orthoptics, vision therapy, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy.

NOTE: For Employees, the Plan Sponsor provides vision care coverage through a separate vision program with Medical Eye Services of California. See "Vision Coverages" in the **Additional Plan Coverages** section.

Vitamins or Dietary Supplements: prescription or non-prescription organic substances used for nutritional purposes. Megavitamin therapy.

Vocational: Vocational testing, evaluation, counseling or training.

Weight Control: Services or supplies for obesity, weight reduction or dietary control, except when Medically Necessary and when prior authorization has been obtained from the Plan.

Wigs or Wig Maintenance: see "Hair Restoration" .

Without approval. Furnished without recommendation and approval of a physician acting within the scope of his or her license.

Weekend admissions: For weekend admission (Friday, Saturday or Sunday) to a hospital unless due to an emergency or if surgery is performed within 24 hours of admission.

Work-related illness or injury: Related to an illness or injury arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, without regard to whether such illness or injury entitles the covered person to workers' compensation or similar benefits.

GENERAL EXCLUSIONS

This section applies to all benefits provided under any section of this summary plan description. This Plan does not cover any charge for services or supplies:

Absence of coverage: That would not have been made in the absence of coverage.

- This includes charges that are submitted to the Plan equal to any amount for which the provider has discounted fees or has "written off" amounts due.

Charges for services that are not actually rendered.

Civil insurrection or riot: Resulting from injuries incurred or exacerbated while participating in a civil insurrection or riot**.**

Complications: That result from complications arising from a non-covered illness or injury, or from a non-covered procedure. This exclusion does not apply to complications of pregnancy.

Cosmetic: For cosmetic surgery or procedures, or aesthetic services (including complications arising therefrom).

- This exclusion does not apply to procedures required as the result of an injury, or if approved as medically necessary for a covered illness.

- This exclusion does not apply to reconstruction of a breast following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all

stages of a mastectomy, including lymphademas, in a manner determined in consultation with the attending physician and the covered person.

Criminal Activities: any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Court-Ordered Care, Confinement or Treatment: any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

Deductibles, Copayments and Coinsurance: That are not payable due to the application of any specified deductible, copayment or coinsurance provisions of the Plan.

Drugs in Testing Phases: Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges: That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Plan Administrator's determination of the usual, customary and reasonable fee for the particular service or supply.

Experimental / Investigational Treatment: Expenses for or in connection with services or supplies that are, as determined by the Plan Sponsor, to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- If required by the FDA, approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of another facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is, experimental, investigational or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if the Plan Sponsor determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, the Plan Sponsor will take into account the results of a review by a panel of independent medical professionals. They will be selected by or on behalf of the Plan Sponsor. The panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND) or Group treatment IND status; or
- Are being supplied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if the Plan Sponsor determines that available scientific evidence demonstrates that the drug is effective, or shows promise of being effective for the disease.

Forms: For the completion of medical reports, claim forms or itemized billings.

Government services: To the extent paid, or which the covered person is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.

Illegal act: Related to injuries sustained, or an illness contracted, during the commission, or attempted commission, of a felony or misdemeanor, or any illegal act or illegal occupation. This exclusion will apply only if the covered person is convicted of the illegal act.

Immediate relative: Provided by an immediate relative or an individual residing in your home.

Late Claims: For which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

Malpractice: That are required as a result of malpractice, malfeasance or misfeasance or that are to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the covered person was under the care of a provider for a condition wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense.

Military service: Resulting from, or prolonged as a result of, performing a duty as a member of the military service **of** any state or country.

Missed appointments: Related to missed appointments**.**

No legal obligation: That are provided to a covered person for which the provider customarily makes no direct charge or for which the covered person is not legally obligated to pay.

Not actually rendered: That are not actually rendered.

Not eligible: That were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided for in this summary plan description.

Not specifically covered: That are not specifically covered under the Plan.

Other Coverage: Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application has been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside of the U.S.A: For any care, services, drugs or supplies incurred outside of the U.S.A. if the covered person traveled to such a location for the purpose of obtaining the care, services, drugs or supplies.

Penalties: That are related to failure to comply with any requirements for coverage under this Plan, or for any copayment amounts identified as a "penalty" in this summary plan description.

Postage, Shipping, Handling Charges, etc. : Any postage, shipping or handling charges which my occur in the transmittal of information to the Contract Administrator, interest or finance charges.

Prior Coverages: Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this document replaces.

Prior to Effective Date / After Termination Date: Charges incurred prior to an individual's effective date of coverage under the Plan pr after coverage is terminated, except as may be expressly stated.

Prohibited by law: For which the Plan is prohibited by law or regulation from providing benefits.

Relative or Resident Care: Any service rendered to a Covered Person by a relative (i.e., spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

School System Services: Services or supplies which any school system is required to provide under any law.

Self-inflicted: Resulting from any intentionally self-inflicted illness or injury.

Subrogation: Reimbursement, and/or Third Party Responsibility: Services, supplies, care, and/or treatment of an injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Tax and shipping: For taxes and shipping charges levied on medically necessary items and services.

Telecommunications: Advice or consultation given by or through any form of telecommunications.

Travel: Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

War: Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication there from.

Work-related Condition: Any sickness that arises out of (or in the course of) any work for pay or profit or results in any way from a disease that does. This will NOT apply, however, if proof is furnished that the person is covered under some type of workers' compensation law and is not covered for the sickness under such law.

An injury that arises out of (or in the course of) any work for pay or profit or results in any way from an injury which does.

With respect to any injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

TERMINATION OF COVERAGE

When does my participation end?
Your participation will end at 12:01 A.M. on the earliest of the following dates:

- The date the Plan terminates;
- The last day of the month for which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution;
- The last day of the month in which you cease to be eligible for coverage under the Plan;
- The last day of the month in which you terminate employment; or
- The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

NOTE: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

When does participation end for my dependents?
The coverage for your dependents will end at 12:01 A.M. on the earliest of the following dates:

- The date the Plan terminates;
- The last date of the month in which the Plan discontinues coverage for dependents;
- The date your dependent becomes covered as an employee under the Plan;
- The last date of the month in which your coverage terminates;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your dependents;
- In the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month in which earliest of the following events occurs:
  - Cessation of the inability;
  - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
  - Upon the child's no longer being dependent on you for his support;
- The last date of the month in which person ceases to be a dependent; or
- The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Will the Plan provide evidence of coverage?
The Plan generally will automatically provide a certificate of coverage to anyone who loses coverage in the Plan. In addition, a certificate of coverage will be provided upon request at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any dependents and to include that information on the certificate of coverage, but the Plan will not issue an automatic certificate of coverage for dependents until the Plan has reason to know that a dependent has lost coverage under the Plan.

Will my participating employer continue our coverage?
Coverage will be continued for you and your dependents should the following occur:

- In the event of a layoff, coverage will continue until the last day of the month following the date of layoff;
- In the event of total disability, coverage will continue for 12 months following termination of active employment; or
- In the event you take a leave of absence which does not meet the requirements of FMLA, your coverage will continue until the last day of the month following the date of the leave of absence.

The period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA.

May I continue participation during FMLA leave?
The Family and Medical Leave Act is a federal law that applies, generally, to employers with 50 or more employees, and provides that an eligible employee may elect to continue coverage under this Plan during a period of approved FMLA leave at the same cost as if the FMLA leave had not been taken.

If provisions under the Plan change while you are on FMLA leave, the changes will be effective for you on the same date as they would have been had you not taken leave.

Am I an eligible employee?
You are an eligible employee if all of the following conditions are met:

- You have been employed with the participating employer for at least 12 months;
- You have been employed with the participating employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
- You are employed at a worksite that employs at least 50 employees within a 75-mile radius.

What circumstances qualify for FMLA leave?
Coverage under FMLA leave is limited to a total of 12 workweeks during any 12-month period that follows:

- The birth of, and to care for, your son or daughter
- The placement of a child with you for adoption or foster care
- Your taking leave to care for your spouse, son or daughter, or parent who has a serious health condition
- Your taking leave due to a serious health condition which makes you unable to perform the functions of your position
- An exigency arising out of the fact that a spouse, son, daughter, parent, or next of kin of the employee has been called to active duty in the Armed Forces in support of a contingency operation (i.e., a war or similar combat operation).

Coverage under FMLA leave is limited to a total of 26 workweeks during any 12-month period that follows a serious illness or injury of a service member when the employee is that service member's primary caregiver.

This leave may be paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. Your participating employer has the right to require that all paid leave be used prior to providing any unpaid leave.

You must continue to pay your portion of the Plan contribution, if any, during the FMLA leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

What are the notice requirements for FMLA leave?
You must provide at least 30 days' notice to your participating employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your participating employer has the right to require medical certification to support your request for leave due to a serious health condition for yourself or your eligible family members.

How long may I take FMLA leave?
During any one 12-month period, the maximum amount of FMLA leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an employee who is the primary care giver of a service member with a serious illness or injury that was incurred in the line of active duty may take up to 26 weeks of

FMLA leave in a single 12-month period to care for that service member. Your participating employer may use any of four methods for determining this 12-month period.

If you and your spouse are both employed by the participating employer, FMLA leave may be limited to a combined period of 12 workweeks, for both spouses, when FMLA leave is due to:

- The birth or placement for adoption or foster care of a child; or
- The need to care for a parent who has a serious health condition.

Will FMLA leave terminate before the maximum leave period?
Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

- When you inform your participating employer of your intent not to return from leave;
- When your employment relationship would have terminated but for the leave (such as during a reduction in force);
- When you fail to return from the leave; or
- If any required Plan contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under FMLA leave ends, you will be eligible for COBRA continuation of coverage at that time.

Recovery of Plan contributions
Your participating employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave if you do not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a serious health condition that entitles you to FMLA leave (in which case your participating employer may require medical certification) or other circumstances beyond your control.

Will my coverage be reinstated when I return to work?
The law requires that coverage be reinstated upon your return to work following an FMLA leave whether or not you maintained coverage under the Plan during the FMLA leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The waiting period limitation will be credited as if you had been continually covered under the Plan.

Definitions
For this provision only, the following terms are defined as stated.

Next of Kin the nearest blood relative to the service member.

Parent is your biological parent or someone who has acted as your parent in place of your biological parent when you were a son or daughter.

Qualifying Exigency includes the following situations:

- Short-notice deployment.
    - To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and

- Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;

- Military events and related activities.

  - To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and

  - To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;

- Childcare and school activities.

  - To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence;

  - To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence;

  - To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and

  - To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;

- Financial and legal arrangements.

  - To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and

  - To act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status;

- Counseling. To attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or for the biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

- Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible employees may take up to five days of leave for each instance of rest and recuperation;

- Post-deployment activities.

    - To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and

    - To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and

- Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the participating employer and employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

Serious health condition is an illness, injury, impairment, or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential medical facility; or

- Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

Serious illness or injury is defined as an illness or injury incurred in the line of duty that may render the service member medically unfit to perform his or her military duties.

Son or Daughter is your biological, child, adopted child, stepchild, foster child, a child placed in your legal custody, or a child for which you are acting as the parent in place of the child's natural blood related parent. The child must be:

- Under the age of 18; or

- Over the age of 18, but incapable of self-care due to a mental or physical disability.

Spouse is your husband or wife.

NOTE: For complete information regarding your rights under FMLA, contact your participating employer.

May I continue participation while I am absent under USERRA?
The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your dependents, where:

- They were covered persons in the Plan immediately prior to your leave of absence for uniformed service; and

- The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

- You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your participating employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

- The cumulative length of this absence and all previous absences with your participating employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

- You comply with the notice requirements set forth in "When will coverage continued through USERRA terminate?"

The law requires your participating employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?
The cost of continuing your coverage will be:

- For leaves of 30 days or less, the same as the contribution required from similarly situated employees;

- For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your participating employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?
Continued coverage under this provision will terminate on the earliest of the following events:

- The date you fail to apply for, or return to, work for your participating employer following completion of your leave. You must notify your participating employer of your intent to return to employment within:

    - For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the participating employer:

        - Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or

        - If reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

    - For leaves of 30 to 180 days, by submitting an application for reemployment with your participating employer:

        - Not later than 14 days after completing uniformed service; or

        - If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.

    - For leaves of more than 180 days, by submitting an application for reemployment with your participating employer not later than 90 days after completing uniformed service.

    - If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for

reemployment with, your participating employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your participating employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

- The date you fail to pay any required contribution.
- For elections before December 10, 2004, 18 months from the date your leave began.
- For elections on or after December 10, 2004, 24 months from the date your leave began.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from USERRA leave?
The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your participating employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your participating employer.

COBRA Continuation Coverage
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA continuation coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your participating employer to see if COBRA applies to you and your dependents.

What is COBRA continuation coverage?
"COBRA continuation coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "qualifying event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your participating employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?
Specific qualifying events are listed below. 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.

If you are a covered employee (meaning that you are an employee and are covered under the Plan), 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 a covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced 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-covered employee dies;
- The parent-covered employee's hours of employment are reduced;
- The parent-covered employee's employment ends for any reason other than his or her gross misconduct;
- The parent-covered employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Los Alamitos Unified School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The participating employer must give notice of some qualifying events

When the qualifying event is the end of employment, reduction of hours of employment, death of the covered employee, commencement of a proceeding in bankruptcy with respect to the employer, or the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the participating employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

Each covered employee or qualified beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

- Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered employee (or former employee) from his or her spouse;
- Notice of the occurrence of a qualifying event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;
- Notice of the occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months;
- Notice that a qualified beneficiary entitled to receive COBRA continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA continuation coverage; and

- Notice that a qualified beneficiary, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Los Alamitos Unified School District
Plan Administrator
10293 Bloomfield Street
Los Alamitos, CA 90720
(562) 799-4700

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice
For qualifying events described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant qualifying event occurs;

- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or

- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;

- The date on which a qualifying event occurs;

- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or

- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA continuation coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the qualified beneficiary is no longer disabled; or

- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost, and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

Who can provide the notice?

Any individual who is the covered employee (or former employee), a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee (or former employee) or qualified beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

Required contents of the notice
The notice must contain the following information:

- Name and address of the covered employee or former employee;
- If you already are receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial qualifying event and its date of occurrence;
- A description of the qualifying event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered employee or former employee, death of the covered employee or former employee, disability of a qualified beneficiary or loss of disability status);
- In the case of a qualifying event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
- In the case of a qualifying event that is Medicare entitlement of the covered employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
- In the case of a qualifying event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age, lost student status, married or other);
- In the case of a qualifying event that is the death of the covered employee or former employee, the date of death, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
- In the case of a qualifying event that is disability of a qualified beneficiary, name and address of the disabled qualified beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
- In the case of a qualifying event that is loss of disability status, name and address of the qualified beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered employee (or former employee), the qualified beneficiaries, the qualifying event or disability, and the date on which the qualifying event, if any, occurred.

Electing COBRA continuation coverage
Complete instructions on how to elect COBRA continuation coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your qualifying event. You then have 60 days in which to elect COBRA continuation coverage. The 60-day period is measured from the later of the date coverage terminates and the date of

the notice containing the instructions. If COBRA continuation coverage is not elected in that 60-day period, then the right to elect it ceases.

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.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA continuation coverage.

How long does COBRA continuation coverage last?

COBRA continuation coverage will be available up to the maximum time period shown below. Multiple qualifying events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original qualifying event. When the qualifying event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original qualifying event. For all other qualifying events, the continuation period is measured from the date of the qualifying event, not the date of loss of coverage.

When the qualifying event is the death of the covered employee (or former employee), the covered employee's (or former 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 covered employee's hours of employment, and the covered employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the covered 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).

Otherwise, when the qualifying event is the end of employment (for reasons other than gross misconduct) or reduction of the covered 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.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of COBRA 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 properly is given to the Plan as set forth above. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the covered 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. An extra fee will be charged for this extended COBRA continuation coverage.

Does COBRA continuation coverage ever end earlier than the maximum periods above?

COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your participating employer ceases to provide a group health plan to any employee;

- The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium;

- The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules). However, a qualified beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA continuation coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or

- The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA continuation coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the qualified beneficiary elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

The Trade Act of 2002
Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the qualified beneficiary elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Special COBRA premium assistance opportunity
The Federal Government through the passage of the "American Recovery and Reinvestment Act of 2009" and the "Department of Defense Appropriations Act, 2010" has made a special COBRA opportunity available for certain assistance eligible individuals.

Additional Information about the Plan
Additional information about the Plan is available from the Plan Administrator, who is:

Los Alamitos Unified School District
Plan Administrator
10293 Bloomfield Street
Los Alamitos, CA 90720
(562) 799-4700, ext. 80409

Additional Information about COBRA
Additional information about COBRA continuation coverage is available from the COBRA Administrator, who is:

BRMS
80 Iron Point Circle, Suite 200
Folsom, CA 95630
(800) 372-0905

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

Prohibition on Rescissions of Coverage (Retroactive Termination)

A health carrier shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

a) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or
b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

To the extent that rescission is permissible, the coverage cannot be cancelled unless the individual is provided with advance notice. The Plan must provide at least 30 calendar days' advance written notice before coverage can be rescinded. The notice must be provided to each participant who would be affected by the recession.

CLAIMS PROCEDURES

You will receive a Plan identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network, and your Cost Containment Program administrator.

At the time you receive treatment from a Network Provider, show your ID card to your provider of service. In most cases, no claim forms are necessary when you use a Network provider. Benefits for Network covered services are always paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

At the time you receive treatment from a Non-Network provider, show your ID card to your provider of service. You might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses if they also submitted a claim. If this happens to you and you have already paid your provider, you must request a refund from your provider. You may file the claim yourself by submitting the required information to:

Benefit & Risk Management Services (BRMS)
80 Iron Point Circle
Suite 200
Folsom, CA 95630
(800) 372-0905

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including PPO network repricing information);

- The name of the Plan;
- The name of the covered employee; and
- The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures For All Claims
The procedures outlined below must be followed by covered persons to obtain payment of health benefits under this Plan.

Health Claims
All claims and questions regarding health claims should be directed to the third party administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the covered person is entitled to them. The responsibility to process claims in accordance with the summary plan description may be delegated to the third party administrator; provided, however, that the third party administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each covered person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the covered person has not incurred a covered expense or that the benefit is not covered under the Plan, or if the covered person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered person or the covered person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  It is important to remember that, if a covered person needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The covered person should obtain such care without delay.

  Further, if the Plan does not require the covered person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The covered person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or
  - The covered person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

Since the Plan does not require the covered person to obtain approval of a medical service in an urgent care situation prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The covered person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the third party administrator within ninety (90) of the date charges for the service were incurred and/or timely based on Network provider contract requirements. Failure to file a claim within this time limit will not invalidate the claim provided that the covered person submits evidence satisfactory to the Plan Administrator that it was not reasonably possible to file the claim within the time limit. In no event will the time limit be extended beyond two (2) years from the date the charges were incurred except in the case of legal incapacity of the covered person. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the third party administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the third party administrator within 45 days from receipt by the covered person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the covered person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Non-urgent Care Claims:

  - If the covered person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the covered person has not provided all of the information needed to process the claim, then the covered person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The covered person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the covered person (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the covered person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The covered person will be notified sufficiently in advance of the reduction or termination to allow the covered person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

  - Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim

and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Post-service Claims.

  - If the covered person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period

  - If the covered person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the covered person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the covered person will be notified of the determination by a date agreed to by the Plan Administrator and the covered person.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the covered person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the covered person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a covered person with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the summary plan description upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures;

- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the covered person's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the covered person, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, or a statement that such explanation will be provided to the covered person, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the covered person believes the claim has been denied wrongly, the covered person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a covered person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- Covered persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

- Covered persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the covered person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

- That a covered person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances.

Requirements for Appeal

The covered person must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the covered person's appeal must be addressed as follows and mailed or faxed as follows:

BRMS
80 Iron Point Circle
Suite 200
Folsom, CA 95630
(800) 372-0905
Fax number: (916) 467-1401

It shall be the responsibility of the covered person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/covered person;

- The employee/covered person's social security number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the covered person will lose the right to raise factual arguments and theories which support this claim if the covered person fails to include them in the appeal**;

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the covered person has which indicates that the covered person is entitled to benefits under the Plan.

If the covered person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the covered person of the Plan's benefit determination on review within the following timeframes:

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a covered person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;

Reference to the specific portion(s) of the summary plan description on which the denial is based;
The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, will be provided free of charge upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final
If, for any reason, the covered person does not receive a written response to the appeal within the appropriate time period set forth above, the covered person may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 120 days after the Plan's claim review procedures have been exhausted.**

Grievance Reporting and Recordkeeping Requirements
The Plan shall maintain written records to document all grievances received, including the notices and claims associates with the grievances, during a calendar year (the register). These records will be maintained by the Plan for at least six (6) years related to the notices provided. The Plan shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.

Appointment of Authorized Representative
A covered person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a covered person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the covered person must complete a form which can be obtained from the Plan Administrator or the third party administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the covered person's medical condition to act as the covered person's authorized representative without completion of this form. In the event a covered person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the covered person, unless the covered person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a physician of its own choosing examine any covered person whose illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The covered person must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased covered person whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered employee whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, the Plan Administrator may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee.

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a covered person to the provider; however, if those benefits are paid directly to the employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers
Medical expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "non-U.S. provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a non-U.S. provider;
- The covered person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person or dependent on whose behalf such payment was made.

A covered person, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a covered person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a covered person, provider or other person or entity to enforce the provisions of this section, then that covered person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Medicaid Coverage
A covered person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such covered person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the covered person, as required by the state Medicaid

program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

"Other Plan"
"Other plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

- Group, blanket, or franchise insurance coverage;
- Blue Cross, Blue Shield, group practice, and other group prepayment coverage;
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;
- Any coverage under governmental programs, and any coverage required or provided by statute; and
- Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

"Allowable Expenses"
"Allowable expenses" shall mean any medically necessary, usual, reasonable and customary item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of other plan(s) for payment of benefits. If you fail to properly file for, and receive payment by, any other plan(s), this Plan will estimate the benefits that would have been otherwise payable and apply that amount, as though actually paid, to the "Application to Benefit Determination" calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the covered person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the covered person used the services of an HMO provider.

"Effect on Benefits"

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. If this Plan is the secondary or subsequent plan, this Plan will pay the balance due up to 100% of the total cumulative allowable expenses for a single claim submission. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

When medical payments are available under automobile insurance, this Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

- The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

- The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the other plan.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;

- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent. If the person on whose expenses the claim is based is an inactive employee (e.g. retired or on layoff) or the dependent of an inactive employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status;

- If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

    - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan

shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan Administrator shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations that the Plan Administrator determines are responsible for payment of such allowable expenses, and any future benefits payable to the covered person or his dependents.

Coordination of Benefits with Medicare
If you are eligible for Medicare, and you are eligible for coverage under this Plan, you may choose to continue coverage under this Plan, and any Medicare benefits to which you are entitled may be used to supplement the benefits of this Plan. If, however, you choose to make Medicare your primary plan, you may not supplement your Medicare coverage with the benefits of this Plan.

In all cases, coordination of benefits with Medicare will conform with Federal law. When coordination of benefits with Medicare is permitted, each individual who is eligible for Medicare will be assumed to have full Medicare coverage whether or not the individual has enrolled for full coverage. Your benefits under this Plan will be coordinated to the extent allowed by Federal law.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

WHEN THIS PROVISION APPLIES: If you, your spouse, one of your dependents, or anyone who receives benefits under this plan becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the plan.

As a condition of receiving benefits under this plan, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that the plan shall have an equitable lien on any funds received by said person and/or their attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the plan may be divided up between the employee or covered person and their attorney if applicable. Any accident related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the plan.

The employee or covered person agrees to take no action which in any way prejudices the rights of the plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny the injured member or any family

member, future benefits by the amount of any recovery received, but not reimbursed, by the Participant as it relates to an accident or injury for which the Plan paid benefits.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

DEFINITIONS

In this section you will find the definitions for the italicized words found throughout this summary plan description. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.**

"Accident" means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

"Actively at work" or "Active employment" means performance by the employee of all the regular duties of his occupation at an established business location of the participating employer, or at another location to which he may be required to travel to perform the duties of his employment. An employee will be deemed actively at work if the employee is absent from work due to a health factor. In no event will an employee be considered actively at work if employment has been terminated.

"ACA" means the Affordable Care Act.

"ADA" means the American Dental Association.

"**Additional Services Not Prohibited**" means that nothing pertaining to Preventive Items and Services prohibit a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in "Coverage for Preventive Items and Services" (see below) even if the treatment results form an item or service described in "Coverage for Preventive Items and Services".

"Adverse Determination" means:

(a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

"Adverse determination" includes a rescission of coverage determination.

"AHA" means the American Hospital Association.

"AMA"means the American Medical Association.

"Ambulance" means an automobile or airplane (fixed wing or helicopter), which is specifically designed and equipped for transporting the sick or injured. It must have patient care equipment, including at least a stretcher, clean linens, first aid supplies and oxygen equipment. It must be staffed by at least two persons who are responsible for the care and handling of patients. One of these persons must be trained in advanced first aid. The vehicle must be operated by a business or agency which holds a license issued by a local, state or national governmental authority authorizing it to operate Ambulances.

"**Ambulatory review**" means utilization review of health care services performed or provided in an outpatient setting.

"Ambulatory surgical center" means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing service whenever a patient is in the institution, and which does not provide service or other accommodations for patients to stay overnight.

"Annual enrollment period" means the period each year during which employees may make new coverage elections.

"**Authorized representative**" means:

(1) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Act;

(2) A person authorized by law to provide substituted consent for a covered person;

(3) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(5) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

"Average Wholesale Price" for any Prescription Drug is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for that drug by the Pharmacy Benefit Manager.

"Biofeedback" biofeedback, recreational or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

"Birthing center" means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located, and provides 24 hour nursing services by registered graduate nurses and certified nurse midwives. An obstetrician or a physician qualified to practice obstetrics with hospital admitting privileges must be available for consultation and referral and on call during labor and delivery. A birthing center must be equipped, staffed, and operating for the purpose of providing:

- Family centered obstetrical care for patients during uncomplicated pregnancy, delivery, and immediate postpartum periods;

- Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and

- Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

A birthing center must have an agreement with an ambulance service and a hospital to accept transfer.

"Brand name drug" means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

"Cardiac care unit" means a separate, clearly designated service area which is maintained within a hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"**Case management**" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

"Certificate of coverage" means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

"**Certification**" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

"Child(ren)" means, in addition to the employee's own blood descendant of the first degree or lawfully adopted child, a child placed with the employee in anticipation of adoption, a child who is an alternate recipient under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the employee has obtained legal guardianship. In order for a child to meet the Plan's definition of a dependent, the child must qualify as a dependent pursuant to Code § 152.

"Chiropractic care" means all services related to a chiropractic visit.

"Claimant" means any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

"**Clinical peer**" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. This may include a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision.

"**Clinical review criteria**" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

"Clinically Stable" means that you are considered clinically stable by your treating physician who believes that, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

"**Closed plan**" means a managed care (EPO-type) plan that requires covered persons to use participating providers

under the terms of the managed care plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Coinsurance" is the percentage of the Covered Expenses for which You are responsible, as specified in the "Schedule of Benefits" section.

"**Commissioner**" means the Commissioner of Insurance.

"Compounded Drugs" are Prescription Drug Orders that are combined or manufactured by the pharmacies and placed in an ointment, capsule, solution or cream using FDA approved drugs and used for a FDA approved indication.

"Company" means Los Alamitos Unified School District.

"Complications of pregnancy" means:

- Conditions whose diagnoses are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, and eclampsia;
- A non-elective cesarean section surgical procedure; or
- A terminated ectopic pregnancy.

Complications of pregnancy does not mean:

- False labor;
- Occasional spotting;
- Prescribed rest during the period of pregnancy; or
- Similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy.

"**Concurrent review**" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

"Copayment" is a fixed dollar fee charged to you for Covered Services and Supplies when you receive them. The amount of each Copayment is indicated in the "Schedule of Benefits" section.

"Contract Administrator" means a company that performs all functions reasonably related to the administration of one or more benefits of the Plan (i.e., processing claims for payment) in accordance with the terms and conditions of the Plan Document and an administration agreement between the contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

"Convalescent Hospital" see also "Skilled Nursing Facility"

"Cosmetic" or" cosmetic surgery" means 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 when necessitated by an injury.

"Coverage for Preventive Items and Services" means that the health plan shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible with respect to the following items and services:

Subsection A:

(1) Except as otherwise provided in Subsection B, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved;

(2) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to women, to the extent not described in Paragraph (1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Subsection B:

(1) (a) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in Subsection A after the recommendation or guideline is no longer described in Subsection A.

(b) Other provisions of State or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including section 2715(d)(a) of the Public Health Services Act, which requires a health carrier to give sixty (60) days advance notice to a covered person before any material modification will become effective.

(2) For purposes of Subsection A and for purpose of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.

"Covered benefits" or "benefits" mean those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered expense" means a medically necessary service or supply which is usual, customary and reasonable, and which is listed for coverage in this Plan.

"Covered person" means a covered employee and his covered dependents, who are eligible for benefits under the Plan.

"Covered Provider" - An individual who is:

licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of his license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

Advanced Clinical Practitioner (LMSW-ACP)

Acupuncturist (CA)
Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Dietician – authorized on a case-by-case basis
Doctors of Osteostophy (DO)
Enterostomal Therapist
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Marriage Family and Child Counselor (MFCC)
Nurse Practitioner
Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Physician Assistant (PA)
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatric Nurse
Psychiatrist (MD)
Registered Nurse (RN)
Research Psychoanalyst
Respiratory Therapist
Speech Pathologist

A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered by the Plan:

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities,

Birthing Centers;

licensed Outpatient mental health facilities;

freestanding public health facilities;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

"Creditable coverage" shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children's Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

"Custodial care" means care or confinement provided primarily for the maintenance of the covered person, essentially designed to assist the covered person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

"Customary and Reasonable Charge", as determined by the Plan Administrator is a charge that falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region, or that is justified based on the complexity or the severity of the treatment for a specific case. Our determination of the Customary and Reasonable Charge is based upon 150% of Medicare rates.

"Deductible" means an amount of money that must be paid by a covered person for covered expenses before the Plan will reimburse additional covered expenses incurred during that plan year.

"Dentist" means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

"Dependent" means one or more of the following person(s):

- An employee's lawfully married spouse possessing a marriage license who is not divorced from the employee;
- An employee's common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the employee has his principal residence;
- A grandfathered in employee's domestic partner who has previously provided the certificate of domestic partnership;
- An employee's child who is less than 26 years of age; or
- An employee's child, regardless of age, who is mentally or physically incapable of sustaining his own living. Such child must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the child attains the limiting age under the bullets above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

"Dependent" does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a dependent relationship.

"Detoxification" means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of substance abuse, is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient to a minimum.

"Diagnostic service" means a test or procedure performed for specified symptoms to detect or to monitor an illness or injury. It must be ordered by a physician or other professional provider.

"**Discharge planning**" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

"Domestic Partner" means a person of the same sex sharing the same residence with the employee, living as a couple in a committed relationship with the employee, and registered with the Secretary of State.

The Plan Administrator reserves the right to require such evidence as it deems necessary that a domestic partner satisfies this definition.

"Drug" means insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed physician.

"Durable medical equipment" means equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

"Effective date" means, July 1, 2004, the original effective date of the Plan.

"**Eligible Expense(s)**" - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

"Emergency" means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an emergency did exist.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention, would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an emergency did exist.

"**Emergency services**" means, with respect to an emergency medical condition:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital to stabilize a patient.

"Employee" means a person who is a regular full-time or part-time employee who has met the eligibility requirements to participate in health benefits and has not waived those benefits. For "eligibility requirements" for benefits please refer to Page 9 of this Plan document. An employee is not a seasonal, temporary or leased employee, or an independent contractor.

"Employer(s)" means the Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

"**Essential health benefits**" has the meaning under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations.

"Essential health benefits" include:

(a) Ambulatory patient services,

(b) Emergency services;

(c) Hospitalization;

(d) Laboratory services;

(e) Maternity and newborn care;

(f) Mental health and substance abuse disorder services, including behavioral health treatment;

(g) Pediatric services, including oral and vision care;

(h) Prescription drugs;

(i) Preventive and wellness services and chronic disease management; and

(j) Rehabilitative and habilitative services and devices.

"Experimental" means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

- Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies. All phases of clinical trials shall be considered experimental.

Drugs are considered experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

"Facility" means an institution providing health care services or a health care , including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

"Family unit" means the employee, their spouse, or existing domestic partner and their dependent children.

"Fiduciary" means any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

"**Final adverse determination**" means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under Section 7 or Section 10 of the Health Carrier Grievance Procedure Act (the Act) or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with Section 6A(2) of this Act.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"FMLA leave" means a leave of absence, which the company is required to extend to an employee under the provisions of the FMLA.

"Generic drug" means drugs not protected by a trademark, usually descriptive of drug's chemical structure.

"GINA" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its participants on the basis of such genetic information.

"Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
(2) Claims payment, handling or reimbursement for health care services; or
(3) Matters pertaining to the contractual relationship between a covered person and a health carrier.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection G, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

"Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

"Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Health benefit plan" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

"Health benefit plan" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

"Health benefit plan" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

"**Health care provider**" or "**provider**" means a health care professional or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

"**Health carrier**" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home health care" means certain services and supplies required for treatment of an illness or injury in the covered person's home as part of a formal treatment plan certified by the attending physician and approved by the Plan Administrator.

"Home health care agency" means an agency or organization which provides a program of home health care and which:

- Is approved as a home health agency under Medicare;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
    - It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
    - It has a full-time administrator;
    - It maintains written records of services provided to the patient;
    - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
    - Its employees are bonded and it provides malpractice insurance.

"Hospice Care Agency" means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a Qualified Practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;

- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and

- Has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an on going quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

"Hospital" means an institution that meets all of the following requirements:

- It provides medical and surgical facilities for the treatment and care of injured or sick persons on an inpatient basis;

- It is under the supervision of a staff of physicians;

- It provides 24-hour-a-day nursing service by registered nurses;

- It is duly licensed as a hospital, except that this requirement will not apply in the case of a state tax-supported institution;

- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a hospital specializing in the care and treatment of mentally ill patients, provided such institution is accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the AMA and the AHA.

"Illness" means a condition, sickness or disease not resulting from trauma.

"Immediate relative" means spouse, child, brother, sister or parent of the covered person, whether by birth, adoption or marriage

"Impregnation and infertility treatment" means diagnostic procedures necessary to determine infertility, artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

"Incurred" means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

"Infertility" exists when any of the following apply to a female Covered Person who has not yet gone through menopause:

- The Covered Person has had regular heterosexual relations for one year or more without use of contraception or other birth control methods and has not become pregnant, or if she became pregnant, could not achieve a live birth; or

- The Covered Person has been unable to achieve conception after six cycles of artificial insemination; or

• The Physician has diagnosed a medical condition that prevents conception or live birth.

"Injury" means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an accident.

"Inpatient" means any person who, while confined to a hospital, is assigned to a bed in any department of the hospital other than its outpatient department and for whom a charge for room and board is made by the hospital.

"Institution" means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a hospital, ambulatory surgical center, psychiatric hospital, community mental health center, residential treatment facility, psychiatric hospital, substance abuse treatment center, alternative birthing center, home health care center, or any other such facility that the Plan approves.

"Intensive care unit" means a separate, clearly designated service area which is maintained within a hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Intermittent Skilled Nursing Services" are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

"Investigational" approaches to treatment are 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. BRMS will decide, based on supporting documentation, whether a service or supply is considered Investigational.

"Leave of absence" means a leave of absence of an employee that has been approved by his participating employer, as provided for in the participating employer's rules, policies, procedures and practices.

"Mastectomy" means the surgical removal of all or part of a breast.

"Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

"Medically necessary" means services or supplies which are determined by the Plan Administrator to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, injury or illness;
- Provided for the diagnosis or direct care and treatment of the medical condition, injury or illness;

- Within standards of good medical practice within the organized medical community;

- Not primarily for the convenience of the covered person, the covered person's physician or another provider; and

- The most appropriate supply or level of service which can safely be provided.

For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the covered person is receiving or the severity of the covered person's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

With regard to Chiropractic Services, "Medically Necessary" services are Chiropractic Services which are appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards of practice.

"**Medically necessary leave of absence**" means a leave of absence by a full-time student dependent in a postsecondary educational institution that:

- Commences while such dependent is suffering from a serious illness or injury;

- Is medically necessary; and

Causes such dependent to lose student status at a postsecondary educational institution for purposes of coverage under the terms of the Plan.

"Medicare" means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental or nervous disorder" means any illness 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.

"**Michelle's Law**" means H.R. 2851.

"Morbid obesity" means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the covered person.

"Network" means the Preferred Provider Organization (PPO) network of providers offering discounted fees for services and supplies to covered persons. The network will be identified on the covered person's Plan Identification Card.

"Out-of-Network Providers" are Physicians, Hospitals or other providers of health care who are not part of the PPO Preferred Provider Organization (PPO).

"Out-of-pocket expense" means the cost to the covered person for deductibles, coinsurance, copayments, penalties and non-covered expenses.

"Outpatient" means services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hosptial facility.

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

"Pain" means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition.

"Participating employer(s)" means Los Alamitos Unified School District.

"**Participating provider**" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

"Pharmacy Benefit Manager" or **"PBM"** is a third party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims. In addition, they develop and maintain the formulary, contract with pharmacies, and negotiate discounts and rebates with drug manufacturers.

"Physician" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

"Plan" means the Los Alamitos Unified School District Employee Benefit Plan.

"Plan Administrator" means Los Alamitos Unified School District.

"Plan Document" means this plan document and summary plan description.

"Plan Sponsor" means Los Alamitos Unified School District.

"Plan year" means the period commencing July 1 and continuing until the next succeeding anniversary.

"PPACA" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

"Pre-admission tests" means those diagnostic services done before a scheduled hospital inpatient admission, provided that:

- The tests are required by the hospital and approved by the physician;
- The tests are performed on an outpatient basis prior to hospital admission;
- The tests are not duplicated on admission to the hospital; and
- The tests are performed at the hospital where the confinement is scheduled, or at a qualified facility approved by the hospital to perform the tests.

"Pre-Existing Condition" means an illness, injury or condition which existed during the 6-month period immediately prior to Your Effective Date, or if there is a waiting period, the first day of the waiting period. An illness, injury or condition is considered to have existed when You: (1) sought or received professional advice for that illness, injury or condition; and (2) received medical care or treatment for that illness, injury or condition.

"Preferred Provider Organization" or **"PPO"** means the network of providers offering discounted fees for services and supplies to covered persons. The network will be identified on the covered person's Plan Identification Card.

"Pregnancy" means carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers pregnancy as an illness for the purpose of determining benefits.

"Prescription Drug" is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be covered Prescription Drugs.

"Prescription Drug Covered Expenses" are the maximum charges the PBM will allow for each prescription drug order. The amount of prescription drug covered expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order. It is not necessarily the amount the pharmacy will bill. Any expense incurred which exceeds the following amounts is not a prescription drug covered expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the prescription drug allowable charge; (b) for prescription drug orders dispensed by a Nonparticipating Pharmacy, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

"Prescription Drug Allowable Charge" is the charge that Participating Pharmacies and the mail service program have agreed to charge Covered Persons, based on a contract between the PBM and such provider.

"Prescription Drug Order" is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness or injury and which is issued by the attending Physician within the scope of his or her professional license.

"Private Duty Nursing" means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care."

"**Privacy Standards"** means the standards for privacy of individually identifiable health information, as enacted pursuant to HIPAA.

"**Prohibition on Recissions of Coverage**" means a health plan shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or

(2) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan.

A health carrier shall provide at least thirty (30) days advance written notice to each plan enrollee or, for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with Subsection A regardless of, in the case of group health insurance coverage, whether the rescission applies to the entire group or only to an individual within the group.

The provisions of this section apply regardless of any applicable contestability period.

"**Prospective review**" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

"Prostheses" are covered as follows:

- Internally implanted devices, such as pacemakers, devices to restore speaking after a laryngectomy and hip joints, which are medically indicated and consistent with accepted medical practice and approved for general use by the Federal Food and Drug Administration;
- External prostheses and the fitting and adjustment of these devices; and
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

For the purpose of this section, external prostheses are those which are:

- Required to replace all or any part of any body organ or extremity; or
- Affixed to the body externally.

In the event that more than one type of prosthesis is available, benefits will be provided only for the device or appliance which is medically and reasonably indicated in accordance with accepted medical practice.

In addition, the following prostheses are covered, but not subject to the benefit maximum shown in the "Schedule of Benefits" section:

- If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prosthesis incident to the mastectomy are covered; and

- Prostheses for restoring a method of speaking (but not including electronic voice boxes) following a laryngectomy are covered.

Repair or replacement of prostheses is covered unless necessitated by misuse or loss. The Plan may, at its option, pay for replacement rather than the repair of an item. Expenses for replacement are covered only when a prosthesis is no longer functional. Certification may be required.

"Provider" means a physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

"Psychiatric hospital" means an institution constituted, licensed, and operated as set forth in the laws that apply to hospitals, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a physician;

- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;

- It is licensed as a psychiatric hospital;

- It requires that every patient be under the care of a physician; and

- It provides 24-hour-a-day nursing service.

It does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care or educational care.

"**Rescission**" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

"Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Residential Treatment Center" is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. It is a requirement that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

"**Rehabilitation hospital"** means an institution which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by Medicare.

"**Retrospective review**" means any review of a request for a benefit that is not a prospective review request.

"Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

"Room and board" means an institution's charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;
- General nursing service; and
- Other conditions of occupancy which are medically necessary.

"Security standards" mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Serious Emotional Disturbances of a child" means when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following;

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas; self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months and are likely to continue for more than a year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title I of the Government Code.

"Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have any creditable coverage.

"Skilled Nursing Facility" - An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;
- is under the full-time supervision of a Physician or a registered nurse;

- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has
- available at all times the services of a Physician;
- has established methods and procedures for the dispensing and administering of drugs;
- has an effective utilization review plan;
- is approved and licensed by Medicare;
- has a written transfer agreement in effect with one or more Hospitals; and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

"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.

"Specialty Pharmacy Vendor" is a pharmacy contracted with the Pharmacy Benefit Manager (PBM) specifically to provide injectable medications, needles and syringes.

"**Stabilized**" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

"Substance abuse" means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

"Substance abuse treatment center" means an institution which provides a program for the treatment of substance abuse by means of a written treatment plan approved and monitored by a physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Licensed, certified or approved as an alcohol or substance abuse treatment program or center by a state agency having legal authority to do so.

"Summary plan description" means this Plan Document and Summary Plan Description.

"Surgery" or "Surgical Procedure" means any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- The induction of artificial pneumothorax and the injection of sclerosing solutions;
- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

- Obstetrical delivery and dilation and curettage; or

- Biopsy.

"Third party administrator" means Benefit & Risk Management Services (BRMS).

"Total disability" or "totally disabled" means the inability of an employee to perform the duties of any occupation for which he may be qualified by reason of training, education or experience. The Plan Administrator may, in its sole discretion, require satisfactory evidence of total disability.

"Trade Act" means the Trade Act of 2002, as amended.

"Uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

"Urgent Care Facility" - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

"**Urgent care request**" means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:

(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(b) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(i) Except as provided in Subparagraph (b) of this paragraph, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Paragraph (1) shall be treated as an urgent care request.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual, customary and reasonable" or "usual, customary and reasonable fees" ("UCR") means services and supplies which are medically necessary for the care and treatment of illness or injury, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Plan Administrator, taking into consideration:

- The fee which the provider most frequently charges the majority of patients for the service or supply;

- The prevailing range of fees charged in the same Area by providers of similar training and experience for the service or supply; and

- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

"Area" means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such services or furnishing such supplies.

"**Utilization review**" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

"Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

"**Waiting period"** means an interval of time during which the employee is in the continuous, active employment of his participating employer before he becomes eligible to participate in the Plan.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the Plan?
The Plan is administered by the Plan Administrator in accordance with applicable law. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a covered person's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the Plan documents and all other records pertaining to the Plan;
- To appoint and supervise a third party administrator to pay claims;

- To perform all necessary reporting as required by applicable law;
- To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

May changes be made to the Plan?
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by applicable law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of covered persons are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Who pays the cost of the Plan?
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the covered person's contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

Will the Plan release my information to anyone?
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or covered person for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the privacy standards. Any covered person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

What if the Plan makes an error?
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to covered persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Will the Plan conform with applicable laws?
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this summary plan description. It is intended that the Plan will conform to the requirements of applicable law, as it applies to employee welfare plans, as well as any other applicable law.

What constitutes a fraudulent claim?
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which you are a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a covered person in the Plan;

- Attempting to file a claim for a covered person for services that were not rendered or drugs or other items that were not provided;

- Providing false or misleading information in connection with enrollment in the Plan; or

- Providing any false or misleading information to the Plan.

How will this document be interpreted?
The use of masculine pronouns in this summary plan description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this summary plan description are used for convenience of reference only. Covered persons are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this summary plan description applies to eligible or covered employees and, where appropriate in context, their covered dependents.

How may a Plan provision be waived?
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this summary plan description a contract between the employer and covered persons?
This summary plan description and any amendments constitute the terms and provisions of coverage under this Plan. The summary plan description shall not be deemed to constitute a contract of any type between the employer and any covered person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this summary plan description shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to discharge any employee at any time.

What if there is coverage through workers' compensation?
This Plan excludes coverage for any injury or illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such injury or illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive workers' compensation coverage for the same injury or illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the injury or illness regardless of the amount or terms of any settlement you receive from workers' compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;

- No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;

- The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or

- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under workers' compensation if a claim for the same injury or illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

Will the Plan cover an alternate course of treatment?
The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this summary plan description.

If a covered person, in cooperation with his provider, elect a course of treatment that is deemed by the Plan Administrator, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the illness or injury, this Plan will allow coverage for the usual, customary and reasonable value of the less costly or extensive course of treatment.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

  - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

    Patricia Meyer

  - The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

  - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and

- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

- Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ADDITIONAL PLAN COVERAGES

The Plan Sponsor offers the following additional coverage(s) to eligible Employees. However, the benefit levels and terms and conditions of the coverages are not described herein. The governing provisions are determined by the insurance company or organization offering each coverage and further information should be obtained from the Employer's personnel office or the office of the Plan Sponsor, if different.

Dental Coverages
Coverage for certain dental services and supplies is provided through a separate dental program. Each Employee will receive separate information describing the details of the program.

Vision Coverages
Coverage for certain vision care services and supplies is provided through a separate vision program. The program, however, applies ONLY to Employees unless an Employee elects to enroll his Dependents and pay the cost of coverage. Each Employee will receive separate information describing the details of the program.

Life and Accidental Death and Dismemberment Insurance
Life and Accidental Death and Dismemberment Insurance is provided through a licensed insurance company. Each Employee will receive a separate certificate describing those benefits and the terms and conditions of that coverage.

The beneficiary for the life insurance will be the person or persons designated on the enrollment card completed for the Contract Administrator or the insurance company. The beneficiary may be changed at any time by making appropriate written request. The Employer's personnel office should be contacted for further information.

NOTE: **COBRA Continuation Coverage** applies only to health care type coverages. It does not apply to life and accidental death and dismemberment insurances.

Prescription Coverage
Coverage for outpatient prescription drug purchases is provided through a separate vendor. A mail-order option for maintenance drugs is also included. The terms of the program(s) are governed by separate agreements between the Plan Sponsor and the vendor(s). However, a brief description of the benefits is included in the **Medical Benefit Summary.**

Adoption of the Plan

The Los Alamitos Unified School District Health and Welfare Benefit Plan, effective 07/01/2017, as amended and restated herein, is hereby adopted as of 07/01/2017. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this Eleventh day of April, 2017.

BY: _____

Patricia L. Meyer

Deputy Superintendent

Self-Funded Plan Amendment
To
Los Alamitos Unified School District Employee Benefit Plan

Plan Sponsor: **Los Alamitos Unified School District**
Amendment: 1.0
Effective Date: July 1, 2018

The Los Alamitos Unified School District Employee Benefit Plan implemented by the undersigned employer is hereby amended to change the following, effective July 1, 2018:

Re: ELIGIBILITY FOR PARTICIPATON – When do I become eligible to participate in the Plan:

NEW EMPLOYEES

As a new employee to the District who meets the FTE level of work stated above, you are eligible for coverage on the latter of the:

- date you meet the eligibility requirements; you're eligible to come on the plan first of the month following date of hire on active payroll.
- date you enroll in the Plan.

You must actually begin work for the District at the required FTE level in order to be eligible. If you are unable to begin work as scheduled, your coverage will be delayed; once you begin work, you will eligible as stated above.

This amendment is hereby adopted by Los Alamitos Unified School District on the first day of July 1, 2018.

By: _____

Title: Asst. Superintendent, Business Services

Self-Funded Plan Amendment
To
Los Alamitos Unified School District Employee Benefit Plan

Plan Sponsor: **Los Alamitos Unified School District**
Amendment: 1.3
Effective Date: March 1, 2020

The Los Alamitos Unified School District's **Employee Benefit Plans** are hereby amended to include the following, effective March 1, 2020:

Re: Los Alamitos USD, COVID-19 and Telemedicine Coverage Inclusion:

COVID-19
Diagnostic and Lab services to diagnose COVID-19 will be covered at 100% under Preventive Care Benefits for In Network Providers only. Care and Treatment of the diagnosed illness will be covered under the members elected plan through Los Alamitos Unified School District and subject to all other Plan provisions including member eligibility at the time services are incurred.

Telemedicine Services
Plan will include Telephone Consultations as a covered Medical Benefit. This will include visits with the member's primary care, specialist providers or mental health provider on an in-network basis only. Care and Treatment of any diagnosed illness will be covered under the member's plan and subject to all other Plan provisions including member eligibility at the time services are incurred. (End Date: 6/30/21)

This amendment is hereby adopted by Los Alamitos Unified School District on March 1, 2020

By: _____

Title: Asst. Supt of Business

Self-Funded Plan Amendment
To
Los Alamitos Unified School District Employee Benefit Plan

Plan Sponsor: **Los Alamitos Unified School District**
Amendment: 1.4
Effective Date: July 1, 2020

The Los Alamitos Unified School District's Employee Benefit Plan is hereby amended to the following, effective July 1, 2020:

Re: Directory of Plan Providers:

Prescription Drug Vendor
Maxor Plus
(800) 658-6146
www.maxor.com

Specialty Prescription Drug Vendor
Maxor Specialty
(866) 629-6779
www.maxor.com

Mail Order Pharmacy Member Services
Maxor Mail
(800) 687-8629
www.maxor.com

Insurance Consultant
Sandy Best
McGriff Insurance Services
750 B Street, Suite 2400
San Diego, CA 92101
(951) 312-8547

This amendment is hereby adopted by Los Alamitos Unified School District on July 1, 2020.

By: _____

Title: Asst. Supt of Business