

CITY OF TULARE

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

ORIGINALLY EFFECTIVE JULY 1, 2012

AS RESTATED JANUARY 1, 2013

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SCHEDULE OF MEDICAL BENEFITS - ACTIVES

Medical Plan - Actives	OPTION 1		OPTION 2 BASE PLAN		OPTION 3		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Individual Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited		
Individual Deductible	\$1,000	\$3,000	\$500	\$1,500	\$0	\$200	Deductibles are combined for in-network and out-of-network services. The family deductible applies collectively to all covered persons in the same family.
Family Deductible	\$2,000	\$9,000	\$1,000	\$4,500	\$0	\$600	
Individual Coinsurance	90%	60%	90%	60%	85%	70%	
Individual Maximum Out-Of-Pocket Amount	\$3,000	\$4,500	\$3,000	\$4,500	\$3,000	\$4,500	Excludes deductible. Maximum out-of-pocket amount is combined for in-network and out-of-network services. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the plan year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	\$6,000	\$13,500	\$6,000	\$13,500	\$6,000	\$13,500	
Preventive Care	100%	60%*	100%	60%*	100%	70%*	Includes all mandated preventive care as required under the Patient Protection & Affordable Care Act (PPACA).
Routine Prostate Screening	100%	60%*	100%	60%*	100%	70%*	Limited to 1 per plan year.
Physician Office Visit	100% after \$10 co-pay	60%*	100% after \$10 co-pay	60%*	100% after \$10 co-pay	70%*	For medically necessary treatment of a covered illness or injury.
Allergy Testing & Injections	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	85% after \$10 co-pay	70%*	
Attention Deficit Disorder	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	85% after \$10 co-pay	70%*	
Health Education Services	90%*	Not covered	90%*	Not covered	85%	Not covered	
Tubal Ligation	100%	Not covered	100%	Not covered	100%	Not covered	
Vasectomy	90%* after \$100 co-pay	Not covered	90%* after \$100 co-pay	Not covered	85% after \$100 co-pay	Not covered	

*Deductible applies

Medical Plan - Actives	OPTION 1		OPTION 2 BASE PLAN		OPTION 3		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Insertion of IUD/ Birth Control Injections	100%	60%*	100%	60%*	100%	70%*	
Prenatal & Postnatal Care Visits	100%	60%*	100%	60%*	100%	70%*	Limited to employee or spouse only.
Breast Pump Rental or Purchase	100%	100%	100%	100%	100%	100%	
Inpatient Hospital Services	90%* after \$100 co-pay	60%*	90%* after \$100 co-pay	60%*	85% after \$100 co-pay	70%*	Precertification is required. Co-pay is waived for admission to Tulare District Hospital. Autologous (self-donated blood) is limited to \$120 per blood unit per scheduled surgery per person.
Physician Inpatient Visit	90%*	60%*	90%*	60%*	85%	70%*	
Outpatient Hospital Services	90%*	60%*	90%*	60%*	85%	70%*	
Surgery & Anesthesia	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required on select surgical procedures.
Cochlear Implants	90%*	60%*	90%*	60%*	85%	70%*	
Organ Transplants	90%*	Not covered	90%*	Not covered	85%	Not covered	Precertification is required. Transportation charges are not covered.
Bone Marrow Transplant – Computerized Search	100%*	Not covered	100%*	Not covered	100%	Not covered	Limited to \$10,000 or 50 potential donors per lifetime, whichever occurs first.
Renal Dialysis	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	85% after \$10 co-pay	70%*	Precertification is required.
Treatment of TMJ	90%*	Not covered	90%*	Not covered	85%	Not covered	
Urgent Care	100% after \$10 co-pay	60%*	100% after \$10 co-pay	60%*	100% after \$10 co-pay	70%*	
Emergency Room Treatment – Emergent Use	90% after \$75 co-pay	Paid at the in-network level	90% after \$75 co-pay	Paid at the in-network level	85% after \$75 co-pay	Paid at the in-network level	Limited to treatment of a medical emergency. Co-pay waived if admitted.
Emergency Room Treatment – Non-emergent Use	60%*	Paid at the in-network level	60%*	Paid at the in-network level	70%	Paid at the in-network level	
Ambulance	90%*	Paid at the in-network level	90%*	Paid at the in-network level	85%	Paid at the in-network level	Limited to a transport during a medical emergency. Precertification is required for non-emergent transport.
Outpatient Diagnostic X-Ray & Laboratory Services	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required on select procedures.

*Deductible applies

Medical Plan - Actives	OPTION 1		OPTION 2 BASE PLAN		OPTION 3		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Genetic Testing & Counseling	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required on select procedures. Limited to treatment if: -there is an immediate family history of a specific disease, -there is an ethnic predisposition to a specific disease, or -the treating physician has a specific concern.
Physical Therapy	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	85% after \$10 co-pay	70%*	Precertification is required for Speech Therapy. Limited to an aggregated maximum of 60 in-network visits per plan year and 30 out-of-network visits per plan year.
Occupational Therapy	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	85% after \$10 co-pay	70%*	
Speech Therapy	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	85% after \$10 co-pay	70%*	
Chiropractic Care	90%* after \$15 co-pay	Not covered	90%* after \$15 co-pay	Not covered	85% after \$15 co-pay	Not covered	Limited to a maximum of 20 visits per plan year.
Skilled Nursing Facility	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required. Limited to a maximum of 100 consecutive days per plan year in-network; and 60 consecutive days per plan year out-of-network.
Home Health Care	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required for out-of-network services. Limited to a maximum of 100 visits each plan year. Further limited to a maximum of 4 home visits per day. (4 hours = 1 visit).
Hospice Care	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required for inpatient care. Limited to 180 days per lifetime.
Durable Medical Equipment	90%*	60%*	90%*	60%*	85%	70%*	Precertification is required on select items.
Inpatient Treatment of Mental Health & Substance Abuse	90%* after \$100 co-pay	60%*	90%* after \$100 co-pay	60%*	85% after \$100 co-pay	70%*	Precertification is required.
Outpatient Treatment of Mental Health & Substance Abuse	100% after \$10 co-pay	60%*	100% after \$10 co-pay	60%*	100% after \$10 co-pay	70%*	
All Other Covered Expenses	90%*	60%*	90%*	60%*	85%	70%*	

* Deductible applies

SCHEDULE OF PRESCRIPTION DRUG BENEFITS - ACTIVES

Prescription Drug Plan - Actives	OPTION 1		OPTION 2 BASE PLAN		OPTION 3		Limitations and Explanations
	Pharmacy	Mail Order	Pharmacy	Mail Order	Pharmacy	Mail Order	
Generic or Single-Source Brand Contraceptive Co-Pay	\$0	\$0	\$0	\$0	\$0	\$0	In all cases, the Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment, unless the physician specifies "Dispense as Written".
Generic Drug Co-Pay	\$15	\$30	\$10	\$20	\$10	\$20	
Brand Drug Co-Pay	\$25	\$50	\$25	\$50	\$15	\$30	
Non-Formulary Drug Co-Pay	\$40	\$80	\$40	\$80	\$30	\$60	
Maximum Supply	30 days	90 days	30 days	90 days	30 days	90 days	Contraceptives that are not generic or single-source brand will be payable under the appropriate co-pay level.

SCHEDULE OF MEDICAL BENEFITS - RETIREES

Medical Plan - Retirees	OPTION 1		OPTION 2 BASE PLAN		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Individual Lifetime Maximum Benefit	Unlimited		Unlimited		
Individual Deductible	\$1,000	\$3,000	\$500	\$1,500	Deductibles are combined for in-network and out-of-network services. The family deductible applies collectively to all covered persons in the same family.
Family Deductible	\$2,000	\$9,000	\$1,000	\$4,500	
Individual Coinsurance	90%	60%	90%	60%	
Individual Maximum Out-Of-Pocket Amount	\$3,000	\$4,500	\$3,000	\$4,500	Option 1 & 2: Excludes deductible. Maximum out-of-pocket amount is combined for in-network and out-of-network services. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the plan year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	\$6,000	\$13,500	\$6,000	\$13,500	
Preventive Care	100%	60%*	100%	60%*	Includes all mandated preventive care as required under the Patient Protection & Affordable Care Act (PPACA).
Routine Prostate Screening	100%	60%*	100%	60%*	Limited to 1 per plan year.
Physician Office Visit	100% after \$10 co-pay	60%*	100% after \$10 co-pay	60%*	For medically necessary treatment of a covered illness or injury.
Allergy Testing & Injections	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	
Attention Deficit Disorder	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	
Health Education Services	90%*	Not covered	90%*	Not covered	
Tubal Ligation	90%* after \$50 co-pay	Not covered	90%* after \$50 co-pay	Not covered	
Vasectomy	90%* after \$100 co-pay	Not covered	90%* after \$100 co-pay	Not covered	
Insertion of IUD/ Birth Control Injections	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	
Prenatal & Postnatal Care Visits	90%*	60%*	90%*	60%*	Limited to employee or spouse only.
Inpatient Hospital Services	90%* after \$100 co-pay	60%*	90%* after \$100 co-pay	60%*	Precertification is required. Co-pay is waived for admission to Tulare District Hospital. Autologous (self-donated blood) is limited to \$120 per blood unit per scheduled surgery per person.
Physician Inpatient Visit	90%*	60%*	90%*	60%*	

*Deductible applies

Medical Plan - Retirees	OPTION 1		OPTION 2 BASE PLAN		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Outpatient Hospital Services	90%*	60%*	90%*	60%*	
Surgery & Anesthesia	90%*	60%*	90%*	60%*	Precertification is required for select surgical procedures.
Cochlear Implants	90%*	60%*	90%*	60%*	
Organ Transplant	90%*	Not covered	90%*	Not covered	Precertification is required. Transportation charges are not covered.
Bone Marrow Transplant – Computerized Search	100%*	Not covered	100%*	Not covered	Limited to \$10,000 or 50 potential donors per lifetime, whichever occurs first.
Renal Dialysis	90%* after \$10 co-pay	60%*	90%* after \$10 co-pay	60%*	Precertification is required.
Treatment of TMJ	90%*	Not covered	90%*	Not covered	
Urgent Care	100% after \$10 co-pay	60%*	100% after \$10 co-pay	60%*	
Emergency Room Treatment – Emergent Use	90% after \$75 co-pay	Paid at the in-network level	90% after \$75 co-pay	Paid at the in-network level	Limited to treatment of a medical emergency. Co-pay waived if admitted.
Emergency Room Treatment – Non-emergent Use	60%*	Paid at the in-network level	60%*	Paid at the in-network level	
Ambulance	90%*	Paid at the in-network level	90%*	Paid at the in-network level	Limited to a transport during a medical emergency. Precertification is required for non-emergent transport.
Outpatient Diagnostic X-Ray & Laboratory Services	90%*	60%*	90%*	60%*	Precertification is required on select procedures.
Genetic Testing & Counseling	90%*	60%*	90%*	60%*	Precertification is required on select procedures. Limited to treatment if: -there is an immediate family history of a specific disease, -there is a ethnic predisposition to a specific disease, or -the treating physician has a specific concern.
Physical Therapy	90%*	60%*	90%*	60%*	Precertification is required for Speech Therapy. Limited to an aggregated maximum of 60 visits per plan year.
Occupational Therapy	90%*	60%*	90%*	60%*	
Speech Therapy	90%*	60%*	90%*	60%*	
Chiropractic Care	90%* after \$15 co-pay	Not covered	90%* after \$15 co-pay	Not covered	Limited to a maximum of 20 visits per plan year.
Skilled Nursing Facility	90%*	60%*	90%*	60%*	Precertification is required. Limited to a maximum of 100 consecutive days per plan year in-network; and 60 consecutive days per plan year out-of-network.

*Deductible applies

Medical Plan - Retirees	OPTION 1		OPTION 2 BASE PLAN		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Home Health Care	90%*	60%*	90%*	60%*	Precertification is required for out-of-network services. Limited to a maximum of 100 visits each plan year. Further limited to a maximum of 4 home visits per day. (4 hours = 1 visit).
Hospice Care	90%*	60%*	90%*	60%*	Precertification is required for inpatient care. Limited to 180 days per lifetime.
Durable Medical Equipment	90%*	60%*	90%*	60%*	Precertification is required on select items.
Inpatient Treatment of Mental Health & Substance Abuse	90%* after \$100 co-pay	60%*	90%* after \$100 co-pay	60%*	Precertification is required.
Outpatient Treatment of Mental Health & Substance Abuse	100% after \$10 co-pay	60%*	100% after \$10 co-pay	60%*	
All Other Covered Expenses	90%*	60%*	90%*	60%*	

*Deductible applies

SCHEDULE OF PRESCRIPTION DRUG BENEFITS - RETIREES					
Prescription Drug Plan - Retirees	OPTION 1		OPTION 2 BASE PLAN		Limitations and Explanations
	Pharmacy	Mail Order	Pharmacy	Mail Order	
Generic Drug Co-Pay	\$15	\$30	\$10	\$20	In all cases, the Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment, unless the physician specifies "Dispense as Written".
Brand Drug Co-Pay	\$25	\$50	\$25	\$50	
Non-Formulary Drug Co-Pay	\$40	\$80	\$40	\$80	
Maximum Supply	30 days	90 days	30 days	90 days	

SCHEDULE OF MEDICAL BENEFITS - RETIREES

Medical Plan - Retirees	OPTION 3		OPTION 4		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Individual Lifetime Maximum Benefit	Unlimited		Unlimited		
Individual Deductible	\$0	\$200	\$3,000	\$5,950	Deductibles are combined for in-network and out-of-network services. The family deductible applies collectively to all covered persons in the same family.
Family Deductible	\$0	\$600	\$6,000	\$11,900	
Individual Coinsurance	85%	70%	85%	70%	
Individual Maximum Out-Of-Pocket Amount	\$3,000	\$4,500	\$5,950	\$5,950	Option 3: Excludes deductible. Option 4: Includes deductible. Maximum out-of-pocket amount is combined for in-network and out-of-network services. When a covered person or family reaches the annual maximum, the Plan pays 100% of additional covered expenses for the remainder of the plan year. Co-pays and penalties do not apply to the out-of-pocket amount.
Family Maximum Out-Of-Pocket Amount	\$6,000	\$13,500	\$11,900	\$11,900	
Preventive Care	100%	70% *	100%	70% *	Includes all mandated preventive care as required under the Patient Protection & Affordable Care Act (PPACA).
Routine Prostate Screening	100%	70% *	100%	70% *	Limited to 1 per plan year.
Physician Office Visit	100% after \$10 co-pay	70% *	85% *	70% *	For medically necessary treatment of a covered illness or injury.
Allergy Testing & Injections	85% after \$10 co-pay	70% *	85% *	70% *	
Attention Deficit Disorder	85% after \$10 co-pay	70% *	85% *	70% *	
Health Education Services	85%	Not covered	85% *	70% *	
Tubal Ligation	85% after \$50 co-pay	Not covered	85% *	70% *	
Vasectomy	85% after \$100 co-pay	Not covered	85% *	70% *	
Insertion of IUD/ Birth Control Injections	85% after \$10 co-pay	70% *	85% *	70% *	
Prenatal & Postnatal Care Visits	85%	70% *	85% *	70% *	Limited to employee or spouse only.
Inpatient Hospital Services	85% after \$100 co-pay	70% *	85% *	70% *	Precertification is required. Co-pay is waived for admission to Tulare District Hospital. Autologous (self-donated blood) is limited to \$120 per blood unit per scheduled surgery per person.
Physician Inpatient Visit	85%	70% *	85% *	70% *	

*Deductible applies

Medical Plan - Retirees	OPTION 3		OPTION 4		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Outpatient Hospital Services	85%	70%*	85%*	70%*	
Surgery & Anesthesia	85%	70%*	85%*	70%*	Precertification is required for select surgical procedures.
Cochlear Implants	85%	70%*	85%*	70%*	
Organ Transplant	85%	Not covered	85%*	70%*	Precertification is required. Transportation charges are not covered.
Bone Marrow Transplant – Computerized Search	100%	Not covered	100%*	70%*	Limited to \$10,000 or 50 potential donors per lifetime, whichever occurs first.
Renal Dialysis	85% after \$10 co-pay	70%*	85%*	70%*	Precertification is required.
Treatment of TMJ	85%	Not covered	85%*	70%*	
Urgent Care	100% after \$10 co-pay	70%*	85%*	70%*	
Emergency Room Treatment – Emergent Use	85% after \$75 co-pay	Paid at the in-network level	85%*	Paid at the in-network level	Limited to treatment of a medical emergency. Co-pay waived if admitted.
Emergency Room Treatment – Non-emergent Use	70%	Paid at the in-network level	70%*	Paid at the in-network level	
Ambulance	85%	Paid at the in-network level	85%*	Paid at the in-network level	Limited to a transport during a medical emergency. Precertification is required for non-emergent transport.
Outpatient Diagnostic X-Ray & Laboratory Services	85%	70%*	85%*	70%*	Precertification is required on select procedures.
Genetic Testing & Counseling	85%	70%*	85%*	70%*	Precertification is required on select procedures. Limited to treatment if: - there is an immediate family history of a specific disease, - there is a ethnic predisposition to a specific disease, or - the treating physician has a specific concern.
Physical Therapy	85%	70%*	85%*	70%*	Precertification is required for Speech Therapy. Limited to an aggregated maximum of 60 visits per plan year.
Occupational Therapy	85%	70%*	85%*	70%*	
Speech Therapy	85%	70%*	85%*	70%*	
Chiropractic Care	85% after \$15 co-pay	Not covered	85%*	Not covered	Limited to a maximum of 20 visits per plan year.
Skilled Nursing Facility	85%	70%*	85%*	70%*	Precertification is required. Limited to a maximum of 100 consecutive days per plan year in-network; and 60 consecutive days per plan year out-of-network.

*Deductible applies

Medical Plan - Retirees	OPTION 3		OPTION 4		Limitations and Explanations
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Home Health Care	85%	70%*	85%*	70%*	Precertification is required for out-of-network services. Limited to a maximum of 100 visits each plan year. Further limited to a maximum of 4 home visits per day. (4 hours = 1 visit).
Hospice Care	85%	70%*	85%*	70%*	Precertification is required for inpatient care. Limited to 180 days per lifetime.
Durable Medical Equipment	85%	70%*	85%*	70%*	Precertification is required on select items.
Inpatient Treatment of Mental Health & Substance Abuse	85% after \$100 co-pay	70%*	85%*	70%*	Precertification is required.
Outpatient Treatment of Mental Health & Substance Abuse	100% after \$10 co-pay	70%*	85%*	70%*	
All Other Covered Expenses	85%	70%*	85%*	70%*	

*Deductible applies

SCHEDULE OF PRESCRIPTION DRUG BENEFITS - RETIREES					
Prescription Drug Plan - Retirees	OPTION 3		OPTION 4		Limitations and Explanations
	Pharmacy	Mail Order	Pharmacy	Mail Order	
Generic Drug Co-Pay	\$10	\$20	85%*	85%*	In all cases, the Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment, unless the physician specifies "Dispense as Written".
Brand Drug Co-Pay	\$15	\$30	85%*	85%*	
Non-Formulary Drug Co-Pay	\$30	\$60	85%*	85%*	
Maximum Supply	30 days	90 days	30 days	90 days	

*Medical deductible applies

TULARE DISTRICT HOSPITAL

PROCEDURES NOT AVAILABLE

The following are a limited example of certain procedures not currently available at the Tulare District Hospital. However, the hospital will assist you in making arrangements at other facilities that may be equipped to perform your specific needs. Please contact the hospital for assistance.

<p>Ancillary Services</p> <ul style="list-style-type: none"> ▪ Organ Bank 	<p>Perinatal / Delivery Services</p> <ul style="list-style-type: none"> ▪ Amniocentesis ▪ Certified Nurse Midwife Program ▪ Extracorporeal Membrane Oxygenation (ECMO) ▪ Fetal Treatment (In-utero Therapy) ▪ In-Vitro Fertilization Program
<p>Diagnostic / Radiology Services</p> <ul style="list-style-type: none"> ▪ Positive Emission Tomography (PET) 	
<p>Radiation Therapy</p> <ul style="list-style-type: none"> ▪ Cobalt Therapy ▪ Gamma Knife ▪ Mega Voltage Radiation Therapy 	
<p>Emergency Services</p> <ul style="list-style-type: none"> ▪ Comp Emergency Med ▪ Designated Trauma Center 	<p>Behavioral Health Services</p> <ul style="list-style-type: none"> ▪ Biofeedback Therapy ▪ Chemical Dependency – Adult ▪ Chemical Dependency – Adolescent ▪ Outpatient – Adult ▪ Outpatient – Adolescent ▪ Psych Locked Unit – Adult ▪ Psych Locked Unit – Adolescent ▪ Inpatient Care – Adult ▪ Inpatient Care – Adolescent ▪ Psychopharmacological Therapy ▪ Recreational Therapy ▪ Residential Care – Adult ▪ Residential Care - Adolescent
<p>Rehab / Long-Term Care</p> <ul style="list-style-type: none"> ▪ Cognitive Rehabilitation 	
<p>Transplant Services</p> <ul style="list-style-type: none"> ▪ Bone Marrow Transplant ▪ Peripheral Stem Cell Marrow Transplant ▪ Heart Transplant ▪ Heart / Lung Transplant ▪ Kidney Transplant ▪ Kidney / Pancreas Transplant ▪ Liver Transplant 	
<p>Cardiology Services</p> <ul style="list-style-type: none"> ▪ Electrophysiology (EPS) 	
<p>Other Services</p> <ul style="list-style-type: none"> ▪ Adult Day Health Care ▪ Outpatient Clinic Services 	

INTRODUCTION

City of Tulare has prepared this document to help you understand your benefits. **PLEASE READ IT CAREFULLY AS YOUR BENEFITS ARE AFFECTED BY CERTAIN LIMITATIONS AND CONDITIONS.** Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them.

This Plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided.

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Definitions section. The headings in the Plan are inserted for convenience of reference only and are not to be construed or used to interpret any of the provisions of the Plan.

As used in this document, the word *year* refers to the *plan year* which begins January 1 and ends December 31. All annual benefit maximums and deductibles accumulate during the *plan year*. The word *lifetime* as used in this document refers to the period of time a covered person is a participant in this Plan sponsored by San Joaquin Valley Insurance Authority.

Benefits described in this document are effective January 1, 2013. The terms and conditions of the City of Tulare Employee Benefit Plan are governed by the provisions in this document. Any and all other written communication regarding the Plan or the benefits provided under the Plan are superseded and are of no force or effect.

This Plan is in compliance with all applicable federal laws. In the event of a change in federal law, the Plan will be deemed to be in compliance and administered accordingly.

ARTICLE I -- ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

You are eligible to participate in this Plan if you are:

1. a regularly scheduled full-time employee of the entity who works a minimum of forty (40) hours per week;
2. a regularly scheduled part-time employee of the entity who works at least twenty (20) hours per week but less than forty (40) hours per week and is enrolled in the entity's retirement plan; or
3. a retiree of the entity with at least ten (10) years of service.

Your eligible dependents may also participate. Eligible dependents include:

1. a legal spouse (excluding a common law spouse), unless legally separated from you.
2. a *domestic partner* (coverage for *domestic partners* is effective July 1, 2013).
3. a child from birth to age twenty-six (26).

The term child includes:

- a. a natural child;
- b. a step-child by legal marriage;
- c. a child who is adopted or has been placed with you for adoption by a court of competent jurisdiction;
- d. a child for whom legal guardianship has been awarded;
- e. a child who is the subject of a *Qualified Medical Child Support Order (QMCSO)* dated on or after August 10, 1993. To be "qualified," a state court medical child support order must specify: the name and last known mailing address of the Plan participant and each alternate recipient covered by the order, a reasonable description of the type of coverage or benefit to be provided to the alternate recipient, the period to which the medical child support order applies, and each plan to which the order applies; and
- f. an unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability and is primarily dependent on you for maintenance and support may continue to be covered under this Plan regardless of age, so long as the disability persists, and the disability began before the child reached age twenty-six (26).

In order to continue coverage, you must furnish written proof of the disability within thirty-one (31) days of the child's twenty-sixth (26th) birthday. The *Plan Administrator* may require you to furnish periodic proof of the child's continued disability but not more

often than annually. If such proof is not satisfactory to the *Plan Administrator*, coverage for the child will end immediately.

You may not participate in this Plan as an employee and as a dependent. However, a person may participate in this Plan as a dependent of more than one (1) employee.

If a covered person under this Plan changes status from employee to dependent or dependent to employee and the person was continuously covered under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

No one who is on active duty with the armed forces will be eligible for coverage under this Plan.

B. Who Pays For Your Benefits

Your employer shares the cost of providing benefits for you and your dependents.

C. Enrollment Requirements

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to your employer within thirty-one (31) days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependents at a later date, you must enroll dependents, including newborns, by properly completing and returning an enrollment form to your employer within thirty-one (31) days of the date they become your dependent(s).

Failure to enroll by the deadline noted above will subject you and your dependents to the Late Enrollment, or Special Enrollment Period provisions below.

Important Note for Newborn and Newly-Adopted Children. If the employee (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the employee, spouse or domestic partner will be covered from the moment of birth; and (2) any child being adopted by the employee, spouse or domestic partner will be covered from the date on which either: (a) the adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the employee, spouse or domestic partner the right to control the health care of the child (in the absence of a written document, other evidence of the employee's, spouse's or domestic partner's right to control the health care of the child may be used); or (b) the employee, spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for thirty-one (31) days. For coverage to continue beyond this 31-day period, the employee must enroll the child within the 31-day period by submitting a membership change form to the *plan administrator*.

D. Late Enrollment

If an eligible employee or dependent declined coverage at the time initially eligible, coverage cannot become effective until the next annual *open enrollment period* unless application for coverage was due to a Special Enrollment as defined under the Special Enrollment Period provision below. The employee or dependent must request enrollment in this Plan within the *open enrollment period*. This provision does not apply to a dependent who becomes eligible for coverage as the result of a *Qualified Medical Child Support Order*, or who is adopted or is placed with you for adoption by a court of competent jurisdiction, as long as he is enrolled within thirty-one (31) days of his eligibility date.

The *enrollment date* for a *late enrollee* is the first day of coverage. Thus, the time between the date a *late enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period*.

E. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a *special enrollee* first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a *waiting period*. Special Enrollment Periods apply to the following:

1. Individuals losing other coverage. An employee or dependent that is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
 - a. The employee or dependent was covered under a group health plan, Medicaid including coverage under state funded Children's Health Insurance Plan (CHIP) or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - b. If required by the *Plan Administrator*, the employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - c. The coverage of the employee or dependent who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated.
 - d. The employee requests enrollment in this Plan not later than:
 - i. thirty (30) days following the termination of coverage or employer contributions, as described above;
 - ii. thirty (30) days following the date COBRA coverage was exhausted;

iii. sixty (60) days following the termination of Medicaid or CHIP.

Coverage begins on the day following the loss of coverage.

If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

2. Dependent beneficiaries. If:

- a. The employee is a participant under this Plan (or has met the *waiting period* applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- b. A person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption then the dependent (and if not otherwise enrolled, the employee) may be enrolled under this Plan as a covered dependent of the employee. In the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage.

The special enrollment period is a period of thirty (30) days that begins on the date of the marriage, birth, adoption, placement for adoption. Coverage begins as of the date of the marriage, birth, adoption or placement for adoption.

3. *Transitional rule dependent* beneficiaries are eligible to enroll in the Plan if either of the following conditions is met:

- a. The dependent beneficiary was previously enrolled in the Plan and their eligibility was terminated due to age; or
- b. The dependent beneficiary was previously not eligible under the Plan when the employee first became eligible as their age at that time exceeded the Plan limitation.

The special enrollment period is a period of thirty (30) days that begins on the date of notification regarding the *transitional rule*. Coverage begins on the date the plan adopts the transitional rule provision.

F. When Coverage Begins

When the enrollment requirements are met, your coverage begins on the first day of the month following thirty (30) days of continuous employment.

Coverage for your eligible dependents begins the later of when your coverage begins or the first day a dependent becomes your dependent.

If two (2) employees (husband and wife) are covered under the Plan and the employee who is covering the dependent children terminates coverage, the dependent coverage may be continued by the other covered employee with no waiting period as long as coverage has been continuous.

However, should coverage commence under the Late Enrollment or Special Enrollment Period sections, the provision under those sections will apply.

Any time you or your eligible dependents have accumulated toward the satisfaction of a *waiting period* under your employer's previous plan will be counted toward the satisfaction of the *waiting period* of this Plan.

G. Pre-Existing Conditions (Not applicable to individuals under the age of 19)

A *pre-existing condition* is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the three (3) month period ending on the person's *enrollment date*. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must be recommended by, or received from, a *physician*.

A *pre-existing condition* does not apply to pregnancy, or to a child who is the subject of a *qualified medical child support order*. *Genetic information* shall not be treated as a *pre-existing condition* in the absence of a diagnosis or the condition related to the *genetic information*.

Claims resulting from *pre-existing conditions*, as defined in the Plan, are excluded from coverage until a period of twelve (12) consecutive months has elapsed from your or your dependent's *enrollment date*, the *pre-existing condition* exclusion will no longer apply and eligible charges incurred thereafter will be considered. In the case of a *late enrollee*, a period of eighteen (18) months must elapse from the first day of coverage.

The pre-existing period will be reduced by the employee's or dependent's period of *creditable coverage* as of the *enrollment date* in this Plan. Days of *creditable coverage* that occur before a *significant break in coverage* are not counted toward the *pre-existing condition* exclusion.

Any time that you or your eligible dependents have accumulated toward the *pre-existing condition* limitation under your employer's previous plan or another health benefit plan sponsored by your employer will be counted toward the satisfaction of the *pre-existing condition* limitation of this Plan.

An eligible person may request a certificate of *creditable coverage* from his or her prior plan. If, after *creditable coverage* has been taken into account, there will still be a *pre-existing condition* limitation imposed on an individual, that individual will be so notified.

(The pre-existing condition limitation is deleted effective January 1, 2014.)

H. When Coverage Ends

Coverage for you and your dependents will end the earliest of the last day of the monthly period for which required contributions have been paid in which one of these events occurs:

1. The date the Plan terminates.

2. The date on which you fail to meet the minimum eligibility requirements.
3. The next monthly required contribution is not paid when due or within the grace period.
4. You are no longer eligible as an employee, including your death.
5. For a spouse, when marriage to the employee is annulled or the spouse becomes legally separated or divorced from the employee.
6. For a child, when they are no longer eligible as a dependent. This includes death or termination of active employment of the covered employee (See the COBRA continuation provision).
7. When a covered employee enters the military of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year.
8. When you cease to maintain full-time residency in the United States of America.

Exception: For employees hired prior to April 1, 1977, the termination date is thirty (30) days following the date of termination.

Note: You must notify the claims administrator when an enrolled family member is no longer eligible to be enrolled as a dependent under the Plan.

I. Extension Of Coverage

If you cease to be eligible for coverage due to a temporary layoff, an approved leave of absence, or a *total disability*, you and your eligible dependents may continue to be covered under the Plan. The benefit termination date will be treated the same as an employment termination date with respect to COBRA Continuation of Benefits.

1. Temporary Layoff

If you are temporarily laid off, eligibility may continue for three (3) consecutive months following the date that the layoff began. Your employment will be considered terminated for benefit purposes on the day following three (3) consecutive months.

2. Leave of Absence

If you qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act of 1993 (FMLA)), eligibility may continue for the duration of the leave. Failure to make payment within thirty (30) days of the due date established by your *employer* will result in the termination of coverage. If you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions that were made on your behalf toward the cost of coverage during the leave.

If you are on any other approved leave of absence, eligibility may continue for three (3) consecutive months following the date that the leave of absence began. Your employment will be considered terminated for benefit purposes on the day following three (3) consecutive months.

3. Total Disability

If you are covered under the Plan and your active service terminates due to *total disability*, you may continue to be covered under the Plan for a period of up to three (3) consecutive months or until the disability ends, whichever occurs first. Your employment will be considered terminated for benefit purposes on the day following three (3) consecutive months. Continuation under this section of the Plan may be combined with that period of time determined to be allowable under the Family and Medical Leave Act of 1993.

You may not be engaged in any other occupation for compensation, profit or gain while *totally disabled*.

J. Reinstatement Of Coverage

If you terminate employment for any reason and are rehired, you will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements. Any covered expenses that you incur will be subject to the *pre-existing conditions* limitation of this Plan.

Exception: If you are returning to work directly from COBRA coverage, you will not have to satisfy a new waiting period and will not be subject to the *pre-existing conditions* limitation of this Plan.

K. The Uniformed Services Employment And Re-employment Rights Act (USERRA)

This Plan will comply with the requirement of all the terms of The Uniformed Services Employment And Re-employment Rights Act of 1994 (USERRA). This is a federal law which gives members and former members of the U.S. armed forces (active and reserves) the right to return to their civilian job they held before military service.

ARTICLE II -- HEALTH CARE MANAGEMENT PROGRAM

A. What Is Health Care Management

Your employer desires to provide you and your family with a health care benefit plan that helps protect you from significant health care expenses and helps to provide you with quality care.

THE PROGRAM IS NOT INTENDED TO DIAGNOSE OR TREAT MEDICAL CONDITIONS, GUARANTEE BENEFITS, OR VALIDATE ELIGIBILITY. The medical professionals who conduct the program focus their review on the appropriateness of treatment. Any questions pertaining to eligibility, Plan limitations or *fee schedules* should be directed to the eligibility and claims department.

Your participating *physician* or *provider* is required to call to obtain certification prior to:

- Any *inpatient hospital* admission including acute rehabilitation and skilled nursing admissions.
- *Inpatient* hospice services.
- All out-of-network home health care and out-of-network home infusion/injectable therapies.
- Hemophilia home infusion.
- Dialysis.
- Certain surgical procedures.
- Organ and bone marrow/stem cell transplants.
- Certain radiological procedures.
- Certain genetic testing procedures.
- Cancer clinical trials.
- Services considered experimental or investigational.
- Electrical bone growth stimulation.
- Intensity-modulated radiation therapy.
- Speech therapy.
- Hyperbaric oxygen therapy.
- Select injectable drugs administered in a *physician's* office.
- Some *durable medical equipment* and medical supplies.
- Myoelectric upper extremity devices.
- Continuous glucose monitoring system.
- Phenylketonuria (PKU) related formulas and special food products.
- Urinary incontinence outpatient program.
- Anesthesia for routine dental procedures.

B. Reduced Benefits For Failure To Follow Required Review Procedures

When the required review procedures outlined above are followed, your benefits will be unaffected. However, failure to comply with this provision may result in a penalty being applied to eligible expenses related to the treatment:

- When services are received from a participating provider, precertification will be obtained by the *health care provider*. If certification is not received, the benefit paid to the provider may be reduced. You can not be billed for the amount of the benefit reduction.
- If services are not provided by a participating provider, you are required to obtain precertification. If precertification is not received, your benefit payment will be reduced by 50%. However, no benefit will be paid toward treatment that is determined not to be *medically necessary*.

ARTICLE III -- PREFERRED PROVIDER ORGANIZATION

A. What Is A PPO

A preferred provider organization (PPO) is a negotiated arrangement in which selected *health care providers* (e.g. *physicians* and *hospitals*) contract to provide services for you and your eligible dependents for a pre-determined price. The PPO arrangement is beneficial to your employer's Benefit Plan, the provider and you.

B. Who Is Your PPO

The PPOs your *employer* has chosen to offer have extensive directories of conveniently located *health care providers*. Your PPO directory contains a list of all participating *physicians* and *hospitals*. If you have any questions regarding a participating provider or network availability, please contact the PPO at the phone number indicated on your identification card.

C. About PPO's

With a PPO, you may see any *health care provider* for covered health care services whenever you like. However, when you see a health care provider who is not a preferred provider, you will receive a lesser benefit as outlined on the Schedule of Medical Benefits, and your out-of-pocket expenses will be greater.

The following PPO exceptions apply to this Plan. In these situations, the Plan will not reduce payment based on the usual and customary allowance:

Any services rendered by an emergency room physician during an in-network emergency room encounter will be considered at the in-network benefit level.

Referrals by in-network providers to out-of-network providers or facilities will be considered at the in-network benefit level.

Professional components charges rendered in a in-network facility regardless of whether the provider is participating with the PPO will be considered at the in-network benefit level.

Any services rendered at an in-network hospital will be reimbursed at the in-network benefit level when the covered person has no choice of facilities or physicians. If the covered person has a choice between an in-network and an out-of-network physician or facility and elects services of an out-of-network facility or physician, then those services rendered will be considered at the out-of-network benefit level.

Services rendered by an out-of-network specialist because one is not available or has not been contracted within the network of specialists will be considered at the in-network benefit level. If a specialist is available within the network and the covered person has elected services from an out-of-network specialist, then those services rendered will be considered at the out-of-network benefit level.

Emergency services at an out-of-network hospital will be paid at the in-network benefit level until the patient is stabilized and can be transferred to the nearest in-network hospital.

Treatment rendered while traveling or residing (for purposes other than seeking medical care) outside the service area of the preferred provider network will be considered at the in-network benefit level.

Services related to medical treatment scheduled prior to July 1, 2012 and rendered by a provider who was a participating network provider under the prior plan will be considered at the in-network benefit until the earlier of the resolution of that medical condition or six (6) months from inception.

ARTICLE IV -- MEDICAL BENEFITS

A. About Your Medical Benefits

All medical benefits provided under this Plan must satisfy some basic conditions. The following conditions which apply to your Plan's benefits are commonly included in medical benefit plans but often overlooked or misunderstood.

1. Medical Necessity

The Plan provides benefits only with respect to covered services and supplies which are *medically necessary* in the specific treatment of a covered *illness* or *injury*, unless specifically mentioned in Covered Medical Expenses. *Medically necessary* means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

"Proven" means the care is not considered *experimental*, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), if applicable.

"Effective" means the treatment's beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, *injury*, *illness* or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan unless specifically mentioned.

2. Usual and Customary Charges

The Plan recognizes only covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where the services or supplies are provided. Any amounts that exceed the *usual and customary charge* are not recognized by the Plan for any purpose and do not accumulate toward the out-of-pocket maximum.

3. Health Care Providers

The Plan provides benefits only for covered services and supplies rendered by a *physician*, *practitioner*, *nurse*, *hospital*, or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

4. Custodial Care

The Plan does not provide benefits for services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

5. Plan Year

The word *year*, as used in this document, refers to the *plan year* which is the period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *plan year*.

6. Alternate Benefit Provision

The *Plan Administrator*, with prior approval from the excess loss carrier, may elect to provide alternative benefits which are not listed as covered services in this contract. The alternative covered benefits should be determined on a case by case basis by the *Plan Administrator* for services which the *Plan Administrator* deems are *medically necessary*, cost effective and agreeable to the covered person and participating provider. The *Plan Administrator* shall not be committed to provide these same, or similar alternative benefits for another covered person nor shall the *Plan Administrator* lose the right to strictly apply the express provisions of this contract in the future.

B. Deductibles

A deductible is the amount of covered expenses you must pay during each *plan year* before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. However, each person cannot contribute more than one individual deductible amount to the family deductible. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *plan year*. The annual individual and family deductible amounts are shown on the Schedule of Medical Benefits.

The deductible is combined for both in-network and out-of-network benefits, and can be satisfied if you and your dependents pay for covered expenses which are incurred for in-network and/or out-of-network services and supplies. Co-payments and penalties are not applied to the deductible.

Any covered expenses that you or your dependents accumulated toward the deductible under your employer's previous plan will be counted toward the satisfaction of the deductible under this Plan.

If two (2) or more covered members of your family are injured in a common accident, the deductible will be applied only once to all involved persons for those injuries.

C. Deductible Carry-Over

When covered expenses incurred in the last three (3) months of the *plan year* are applied to the deductible, that amount will also be used to satisfy the deductible for the following *plan year*.

D. Coinsurance

Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed *usual and customary charges*. You are responsible for all non-covered expenses and any amount which exceeds the *usual and customary charge* for covered expenses.

The coinsurance percentages are shown on the Schedule of Medical Benefits.

E. Maximum Out-Of-Pocket Amount

A maximum out-of-pocket amount is the maximum amount of covered expenses you must pay during a *plan year* before the payment percentage of the Plan increases. The individual maximum out-of-pocket amount applies separately to each covered person. When a covered person reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that individual during the remainder of that *plan year*.

The family maximum out-of-pocket amount applies collectively to all covered persons in the same family. When the family reaches their annual maximum out-of-pocket amount, the Plan will pay one hundred percent (100%) of additional covered expenses, subject to any applicable co-payments, for that family during the remainder of that *plan year*.

Any covered expenses that you or your dependents accumulated toward the maximum out-of-pocket amount under your previous employer's plan will be counted toward the satisfaction of the maximum out-of-pocket amount under this Plan.

The maximum out-of-pocket amount excludes charges in excess of the *usual and customary charge*, any co-payments and any penalties for failure to comply with the requirements of the Health Care Management Program.

The annual individual and family maximum out-of-pocket amounts are shown on the Schedule of Medical Benefits.

F. Benefit Maximums

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the time you or your dependents are covered by this Plan. The benefit maximums applicable to this Plan are shown in the Schedule of Medical Benefits.

G. Covered Medical Expenses

When all of the requirements of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits but only for the services and supplies listed in this section.

Hospital Services

1. Room and board, not to exceed the cost of a semiprivate room or other accommodations unless the attending *physician* certifies the *medical necessity* of a private room. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in the geographic area.

The Plan may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

The attending provider, after consulting with the mother, may discharge the mother and newborn earlier than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section.

2. *Intensive care unit* and coronary care unit charges.
3. Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.
4. Well-baby nursery and *physician* expenses during the initial *hospital* confinement of a newborn.
5. *Hospital* confinement expenses for dental services if the attending *physician* certifies that hospitalization is necessary to safeguard the health of the patient.
6. *Outpatient hospital* services.

Emergency Services

1. Treatment in a *hospital* emergency room or other emergency care facility.
2. Ground transportation provided by a professional ambulance service for the first trip to and from the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as a *medical emergency*.
3. Transportation provided by a professional air ambulance service for the first trip to and from the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as a *medical emergency*.

Specialized Treatment Facilities

1. A *skilled nursing facility* or extended care facility. The room and board and nursing care furnished by a *skilled nursing facility* will be payable if and when:
 - a. the patient is confined as a bed patient in the facility;
 - b. the attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement; and
 - c. the attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the *skilled nursing facility*.
2. An *ambulatory surgical facility*.
3. A *birthing center*.
4. A mental health treatment facility.
5. A substance abuse treatment facility.
6. A *hospice facility* when a *physician* certifies life expectancy is six (6) months or less. Bereavement counseling received within the six (6) month period following the patient's death for covered family members is included.
7. A *partial hospitalization treatment facility*.

Surgical Services

1. Surgeon's expenses for the performance of a surgical procedure.
2. Assistant surgeon's expenses not to exceed twenty percent (20%) of the *usual and customary charge* of the surgical procedure.
3. Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *usual and customary charge* for the largest amount billed for one (1) procedure plus fifty percent (50%) of the sum of *usual and customary charges* for all other procedures performed.
4. Anesthetic services, when performed by a licensed anesthesiologist or certified registered *nurse* anesthetist in connection with a surgical procedure.
5. *Oral surgery*, limited to the removal of tumors and cysts; incisions of sinuses, salivary glands, or ducts; frenectomy; cleft lip and palate; extracting partial or completely unerupted teeth; and treatment of an accidental *injury* to sound and natural teeth. Treatment of an accidental *injury* must be completed within twelve (12) months of the date of the *injury*.
6. Reconstructive *surgery*:
 - a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part;
 - b. when needed to correct damage caused by an *illness* or accidental *injury*; or
 - c. breast reconstructive *surgery* in a manner determined in consultation with the attending *physician* and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, *surgery* and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998.

If a participant had a mastectomy prior to the effective date of their coverage on this Plan, the Plan will not provide coverage for a symmetrical appearance, unless the participant is still receiving follow-up care related to the mastectomy.

7. Non-experimental organ and tissue transplant services to an organ transplant recipient who is covered under this Plan. In addition, benefits will be provided for *inpatient hospital* expenses of the donor of an organ for transplant to a covered recipient and for *physician's* expenses for surgical removal of the donor organ if the donor does not have coverage through another group plan. This benefit begins on the day of *surgery* and continues for up to ten (10) additional consecutive days. No benefits will be provided for organ selection, transportation and storage costs, or when benefits are available through government funding of any kind. If the organ or tissue donor is covered under this Plan and the recipient is not, then the Plan will cover donor organ or tissue charges for evaluating the organ or tissue and removing the organ or tissue from the donor.
8. Circumcision.
9. *Outpatient surgery*.
10. Amniocentesis when the attending *physician* certifies that the procedure is *medically necessary*.
11. Surgical treatment of *morbid obesity*, limited to *medical necessity*.
12. Surgical treatment of temporomandibular joint dysfunction (TMJ) and other craniomandibular disorders.
13. Voluntary sterilization. If sterilization is the primary procedure for a woman, all services rendered on the date of the procedure will be payable as a Preventive Care benefit. If sterilization is a secondary procedure, the surgeon's bill will be payable as a Preventive Care benefit.
14. Voluntary termination of pregnancy, limited to in-network services.

Mental Health Conditions and Substance (Drug or Alcohol) Abuse Treatment

1. *Inpatient* mental health and substance abuse treatment.
2. *Outpatient* mental health and substance abuse treatment.
3. Treatment of an eating disorder, following initial visit to a *physician* for diagnosis.
4. Partial hospitalization.

Medical Services

1. *Physician* office visits relating to a covered *illness* or *injury*, or for the insertion of an intrauterine device or injection of contraceptives.

2. Initial physician examination and subsequent physician office visits for prescription of medication for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).
3. *Inpatient physician* visits by the attending or non-attending *physician*.
4. *Second/third* (if *medically necessary*) *surgical opinions*.
5. Pregnancy and related maternity care for employees and their covered spouses. Coverage for dependent daughters is limited to complications of pregnancy only.
6. Charges for the diagnosis of infertility.
7. Dental services received after an accidental *injury* that occurred while covered under this Plan to sound and natural teeth including replacement of such teeth; and any related x-rays and dental services must be completed within twelve (12) months of the date of the *injury*. Eligible expenses for necessary hospitalization, including prescription drug charges, incurred in conjunction with other dental care may be considered for payment if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition.
8. Radiation therapy.
9. Chemotherapy.
10. Hemodialysis, including acute and chronic services. For chronic hemodialysis, application for Medicare Part A and B must be made.
11. Chiropractic services excluding *maintenance care* and palliative treatment.
12. Podiatric services for treatment of an *illness or injury*, or due to metabolic or peripheral vascular disease.
13. Physical therapy, excluding *maintenance care* and palliative treatment.
14. Cardiac rehabilitation, as deemed medically necessary, provided services are rendered:
 - a. under the supervision of a physician;

- b. in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
 - c. initiated within twelve (12) weeks after other treatment for the medical condition ends; and
 - d. in a medical care facility as defined by this Plan.
15. Non-custodial services of a *nurse* which are not billed by a *home health care agency*.
16. Home health care that is provided by a *home health care agency* (four (4) hours = one (1) visit). The following are defined as covered home health care services and supplies upon referral of the attending *physician*:
- a. part-time nursing services provided by or supervised by a registered *nurse* (R.N.);
 - b. part-time or intermittent home health aide services;
 - c. physical, occupational, speech or respiratory therapy which is provided by a qualified therapist;
 - d. nutritional counseling that is provided by or under the supervision of a registered dietician;
 - e. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.
17. *Hospice care* (including bereavement counseling) provided that the covered person has a life expectancy of six (6) months or less and subject to the maximums, if any, as set forth in the Schedule of Benefits. Covered *hospice care*, *respite care* and bereavement expenses are limited to:
- a. room and board for confinement in a *hospice facility*;
 - b. ancillary charges furnished by the hospice while the patient is confined therein, including rental of *durable medical equipment* which is used solely for treating an *injury* or *illness*;
 - c. nursing care by a registered *nurse*, a licensed practical *nurse*, or a licensed vocational *nurse* (L.V.N.);
 - d. home health aide services;

- e. home care charges for home care furnished by a *hospital* or *home health care agency*, under the direction of a hospice, including custodial care if it is provided during a regular visit by a registered *nurse*, a licensed practical *nurse*, or a home health aide;
 - f. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.
 - g. medical social services by licensed or trained social workers, psychologists, or counselors;
 - h. nutrition services provided by a licensed dietician;
 - i. counseling and emotional support services by a licensed social worker or a licensed pastoral counselor;
 - j. bereavement counseling by a licensed social worker or a licensed pastoral counselor for the covered person's immediate family received within the six (6) month period following the patient's death;
 - k. *respite care*.
18. Speech therapy from a licensed speech therapist. Therapy must be ordered by a physician and follow either:
- a. surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;
 - b. an injury; or
 - c. an illness that is other than a learning or mental disorder.
- If the loss of speech is due to a congenital condition, any required corrective *surgery* must have been performed prior to the therapy.
19. Occupational therapy by a licensed occupational therapist, but not to include vocational, educational, recreational, art, dance or music therapy, or supplies. Therapy must be ordered by a *physician*, result from an *injury* or *illness* and improve a body function.
20. Initial examination for the treatment of eating disorders (e.g., bulimia, anorexia). Subsequent treatment is eligible for consideration as a mental health disorder.
21. Allergy testing and treatment.

22. Preparation of serum and injections for allergies.
23. Temporomandibular joint dysfunction (TMJ): non-surgical treatment or treatment for prevention of TMJ, craniomandibular disorders, and other conditions of the joint linking the jawbone and skull, muscles, nerves, and other related tissues to that joint.
24. Charges related to a provider discount for covered medical expenses resulting in savings to this Plan.
25. Counseling classes, including education material on various health subjects, such as prenatal care and family planning, as presented by the primary care physician health education staff or their designee.
25. Diabetes education programs.
26. Care and treatment for sleep disorders when *medically necessary*.
27. *Medically necessary* services rendered in connection with an *approved clinical trial* (effective January 1, 2014).

Diagnostic X-Ray and Laboratory Services

1. *Diagnostic charges* for x-rays, excluding dental x-rays.
2. *Diagnostic charges* for laboratory services.
3. Preadmission testing (PAT). The medical benefits percentage payable will be considered for diagnostic lab tests and x-rays when:
 - a. performed on an outpatient basis within four (4) days before a *hospital* confinement;
 - b. related to the condition which causes the confinement; and
 - c. performed in place of tests while *hospital* confined.

Covered charges for this testing will be payable even if tests show the condition requires medical treatment prior to *hospital* confinement or the *hospital* confinement is not required.

4. Ultrasounds, prenatal laboratory and pregnancy testing.
5. Genetic testing and counseling if:
 - a. there is an immediate family history of a specific disease;
 - b. there is an ethnic predisposition to a specific disease; or
 - c. the treating physician has a specific concern.

Equipment and Supplies

1. *Durable medical equipment*, including iron lung, oxygen tent, hospital bed, wheelchair and similar medically necessary durable medical equipment and related consumable and/or disposable supplies. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased.

Benefits are not provided for durable medical equipment that is more elaborate or customized than the cost of the least expensive adequate equipment. No benefits will be provided in subsequent plan years for charges not initially reimbursed because the maximum had been reached.

Charges for replacement will be covered only when required because of pathological change, or the natural growth process of a child under the age of nineteen (19). Charges for maintenance are not covered. Repair or replacement of equipment due to normal use or growth of a child is covered.

Medical supplies and orthopedic appliances include items such as braces, rib belts and crutches.

2. Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or, replacement is less expensive than repair of existing equipment.
3. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.
4. Blood and/or plasma, if not replaced, and the equipment for its administration including autologous blood transfusions. The donation and storage of the enrollee's blood for their own planned surgery is also covered.
5. Insulin infusion pumps and supplies.
6. Initial prescription contact lenses or eye glasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* or when required as the result of an *injury*.
7. Examination for or the purchase or fitting of hearing aids when required as the result of an *injury*.

8. Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, prosthetic appliances (excluding bionic and myoelectric) or orthotics (only when attached to a brace), when prescribed by a *physician*, to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the covered person.
9. Sterile surgical supplies after *surgery*.
10. Drugs, medicines, or supplies dispensed through the *physician's* office, for which the patient is charged.
11. Take home prescription drugs from a *hospital*, for which the patient is charged.
12. Cochlear implantable devices for bilateral, profoundly hearing-impaired individuals not benefited from conventional amplification (hearing aids). Short-term hearing rehabilitation is also covered.
13. Wigs, limited to initial purchase of a wig due to hair loss directly related to chemotherapy or radiation treatment.
14. HPV vaccination.
15. Contraceptives dispensed in a physician's office.
16. Breast pump rental during the postpartum period for the duration of breast feeding. Purchase of one manual or electric breast pump (non-hospital grade) will be covered in lieu of rental if purchased within three (3) months following the delivery date.

Preventive Care

Preventive care includes all mandated preventive care as required under the Patient Protection and Affordable Care Act.

H. Medical Expenses Not Covered

The Plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. The Plan only covers those expenses for services and supplies specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

General Exclusions

1. Expenses exceeding the *usual and customary charge* for the geographic area in which services are rendered.
2. Expenses unnecessary for diagnosis of an *illness* or *injury*, except as specifically mentioned in Covered Medical Expenses.
3. Treatment not prescribed or recommended by a *health care provider*.
4. Services, supplies, or treatment not *medically necessary*.
5. Experimental equipment, services, or supplies which have not been approved by the United States Department of Health and Human Services, the American Medical Association (AMA), or the appropriate government agency.
6. Services furnished by or for the United States Government or any other government, unless payment is legally required.
7. Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and for which the covered person benefits are provided under Worker's Compensation Laws or similar legislation.
8. Any condition, disability, or expense sustained as a result of being engaged in: an illegal occupation; commission or attempted commission of an assault or other illegal act; participating in a civil revolution or riot; duty as a member of the armed forces of any state or country; or a war or act of war which is declared or undeclared.
9. Educational, vocational, or training services and supplies, except as specifically mentioned in Covered Medical Expenses.
10. Expenses for telephone conversations, charges for failure to keep a scheduled appointment, or charges for completion of medical reports, itemized bills, or claim forms.
11. Mailing and/or shipping and handling expenses.
12. Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
13. Medical treatment and travel outside of the United States if the sole purpose of the travel is to obtain medical service, supplies or drugs.
14. Communication, transportation expense, or travel time of *physicians* or *nurses*.

15. Charges resulting from penalties, exclusions, or charges in excess of allowable limits imposed by HMO, non-HMO, or PPO providers resulting from failure to follow the required procedures for obtaining services or treatment.
16. Services or supplies for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan.
17. Professional services performed by a person who ordinarily resides in your household or is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.
18. Intentionally self-inflicted *injury* or *illness* while sane or insane and suicide or any attempt to commit suicide while sane or insane, except a self-inflicted *injury* or *illness* that is the result of a physical or mental medical condition.
19. Expenses used to satisfy Plan deductibles, co-payments, or applied as penalties.
20. Expenses eligible for consideration under any other plan of the *employer*.
21. Expenses incurred as the result of an auto accident up to the amount of any state required automobile insurance with respect to those expenses.
22. Expenses incurred for services rendered prior to the effective date of coverage under this Plan or expenses for services performed after the date coverage terminates.
23. Charges for services provided in a medical or dental department or clinic maintained by an employer, labor union or mutual benefit organization.
24. Any services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated hospital or Medicare-approved skilled nursing facility, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated are not covered.
25. Care and treatment billed by a hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within twenty-four (24) hours of admission.
26. Services performed by volunteer workers.

Additional Exclusions

The following exclusions are in alphabetical order to assist you in finding information quickly; however, you should review the entire list of exclusions when trying to determine whether a particular treatment or service is covered as the wording of the exclusion may place it in a different location than you might otherwise expect.

1. Abortion, when services are obtained out-of-network.
2. Acupuncture and acupressure.
3. Adoption expenses.
4. Allergy testing and treatment procedures, limited to urine auto-injection and skin titration/rinkel method.
5. Amniocentesis charges except when done in the last trimester for the purpose of determining fetal lung maturity or in the first sixteen (16) weeks for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother.
6. Biofeedback.
7. Breast prosthetic implant removals whether inserted for cosmetic reasons or due to a mastectomy are not covered, unless the removal is *medically necessary*.
8. Complications arising from any non-covered *surgery* or treatment.
9. *Cosmetic* or reconstructive *surgery* unless specifically mentioned in Covered Medical Expenses.
10. Dental services, dental appliances, or treatment including hospitalization for dental services, except as specifically mentioned in Covered Medical Expenses.
11. Donor expenses unless specifically mentioned in Covered Medical Expenses.
12. Drugs, medicine, or supplies that do not require a *physician's* prescription.
13. Education, counseling, or job training for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or mental health treatment.
14. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.
15. Eyeglasses or lenses, orthoptics, vision therapy, or supplies unless specifically mentioned in Covered Medical Expenses.
16. Family counseling.

17. Foot treatment, palliative or cosmetic, including flat foot conditions, supportive devices for the foot, orthopedic or corrective shoes, specialized or customized footwear, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
18. Hearing examinations, hearing aids, or related supplies unless specifically mentioned in Covered Medical Expenses.
19. *Hospital* confinement for physiotherapy, hydrotherapy, convalescent care, or rest care.
20. Hypnosis.
21. Impotence medications.
22. Infertility treatment including, but not limited to, fertility drugs, artificial insemination, in-vitro, in-vivo fertilization or diagnosis and treatment of sexual dysfunctions and defects not related to organic disease, or treatment relating to the inability to conceive.
23. Kerato-refractive eye *surgery* (to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis *surgery*).
24. Massage therapy or rolfing.
25. Marital counseling.
26. Non-routine services rendered in connection with an *approved clinical trial*, including:
 - a. The *experimental* treatment, procedure, device or drug itself.
 - b. Items or services provided solely to satisfy data collection and analysis.
 - c. Items or services customarily provided by the research sponsors free of charge.
 - d. Items or services provided solely to determine trial eligibility.
27. Nutritional supplements or formulas.
28. Orthodontics for cleft palate.
29. Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities.
30. Orthotics when not attached to a brace.

31. Personal comfort or service items while confined in a *hospital* including, but not limited to, radio, television, telephone, and guest meals.
32. Pregnancy and related maternity care for dependent daughters or coverage for their babies. However, complications of pregnancy are covered.
33. Prescription drugs or medicines other than specifically mentioned in any Covered Medical Expenses section.
34. Preventive care unless specifically mentioned in Covered Medical Expenses.
35. Private duty nursing care.
36. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional.
37. Reversal of any elective surgical procedure.
38. Sales tax.
39. Sanitarium, rest, or *custodial care*.
40. Sex change *surgery* or disorders. Care, services, diagnosis or treatment for non-congenital transsexualism, sexual dysfunctions, dementia, gender dysphasia or sexual reassignment, change or defects whether or not they are the consequence of illness or injury. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment. Examples are impotence, frigidity and infertility.
41. Sex counseling.
42. Sleep disorders, care and treatment of, unless deemed *medically necessary*.
43. Smoking cessation programs, smoking cessation medications, or *physician's* office visits for smoking cessation treatment.
44. Social services, dietary assistance, "Meals on Wheels" or nutritional guidance.
45. Surrogate expenses, including use of a surrogate by a covered individual or services as a surrogate by a covered individual.
46. Vitamins and nutritional supplements, regardless of whether or not a *physician's* prescription is required.

47. Weight reduction or control, including treatments, instructions, activities, or drugs and diet pills, whether or not prescribed by a *physician*, except as specifically mentioned in Covered Medical Expenses.

48. Wigs and artificial hair pieces, except as specifically mentioned in Covered Medical Expenses.

Limitation Caution

If the provisions of any covered services provided are delayed or rendered impractical due to circumstances not within the control of this Plan, including but not limited to, a major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability or significant part of participating provider's personnel or similar causes, this Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the covered services provided insofar as practical, and according to their best judgment, this Plan shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

ARTICLE V -- PRESCRIPTION DRUG PLAN

A. About Your Prescription Drug Benefits

The prescription drug program is an independent program, separate from the regular medical plan and administered by Catalyst Rx.

The coverage is for prescription drug costs incurred by you, your spouse and your eligible dependents. You will receive an identification card when you become covered. In order to use your prescription card, simply go to any participating pharmacy. Present your identification card to the pharmacist, sign the claim form or signature log, and pay your appropriate co-payment.

If you choose to use a non-participating pharmacy or do not have your identification card, you must pay the pharmacist the full amount for the prescription. The pharmacy should complete the section of the direct reimbursement form which may be obtained from your *employer*. You complete your section of the form and send the completed form to Catalyst Rx with your receipt. You will be reimbursed the amount that would have been paid to the participating pharmacy, less the applicable co-payment. In order to receive the full benefit of your Prescription Drug Plan you must use a participating pharmacy and present your card.

B. Covered Prescription Drugs

Prescriptions covered under your Plan include all drugs bearing the legend “Caution: Federal law prohibits dispensing without a prescription” except as identified in Prescription Drugs Not Covered.

The following are specifically covered by this Plan when accompanied by a *physician's* prescription.

1. Diabetic medications, including insulin, injectables and anti-hyperglycemic injectables.
2. Diabetic supplies, including disposable needles, syringes, testing agents, test strips, lancets, lancet devices, glucose elevating agents, alcohol swabs and calibration solution.
3. Contraceptives: oral, extended-cycle oral, emergency, transdermal and implantable contraceptives; diaphragms, intrauterine devices and intravaginal rings.
4. Injectable fertility agents.
5. Impotence medications. Pills are limited to six (6) per every thirty (30) days.
6. Vitamins.

7. Topical acne agents for individuals through age twenty-four (24).
8. Oral acne medications.
9. Anti-obesity medications.
10. Smoking deterrents, limited to a lifetime maximum of \$500.
11. A.D.D./Narcolepsy medications for individuals through age nineteen (19).
12. Anabolic steroids.
13. Injectable legend drugs, except those specifically mentioned in Prescription Drugs Not Covered.
14. Compounded medication of which at least one (1) ingredient is a legend drug.
15. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a *physician* or other lawful prescriber.

C. Dispensing Limitations

Prescriptions are covered for up to a thirty (30) day supply, or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops. Three (3) co-pays will apply to the purchase of extended cycle oral contraceptives.

D. Co-Payments

The co-payment amounts for generic and brand name prescriptions or refills are shown on the Schedule of Prescription Drug Benefits. The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the *physician* specifies “Dispense as Written”.

E. Prescription Drugs Not Covered

1. Contraceptives, except those specifically mentioned in Covered Prescription Drugs.
2. Non-injectable fertility agents or medications.

3. Fluoride supplements.
4. Cosmetic medications, including but limited to, anti-wrinkle agents, hair growth stimulants, hair removal products and pigmenting/depigmenting agents.
5. Topical acne agents for individuals age twenty-five (25) and older.
6. A.D.D./Narcolepsy medications for individuals age twenty (20) and older.
7. Immunization agents.
8. Blood or blood plasma.
9. Non-legend drugs except those specifically mentioned in Covered Prescription Drugs.
10. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those specifically mentioned in Covered Prescription Drugs.
11. Charges for the administration or injection of any drug.
12. Drugs labeled “Caution: Limited by Federal law to investigational use,” or *experimental* drugs even though a charge is made to the individual.
13. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, *skilled nursing facility*, convalescent *hospital*, nursing home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
14. Any prescription refilled in excess of the number specified by the *physician*, or any refill dispensed more than one (1) year from the *physician's* original order.

F. Mail Service Prescription Drug Program

The mail service prescription drug program is offered when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be anything up to a ninety (90) day supply, or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops.

The co-payment amounts for generic and brand name prescriptions or refills are shown on the Schedule of Prescription Drug Benefits. The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the *physician* specifies “Dispense as Written”.

Prescription medications which are covered by your Prescription Drug Plan are also covered if they are normally available at your local pharmacy. However, certain medications cannot be supplied by mail easily (for example, drugs requiring constant refrigeration) and are not available through this program.

The law requires that pharmacies dispense the exact quantity prescribed by the *physician*. So if your *physician* authorizes the maximum order quantity, the prescription must be for a ninety (90) day supply for you to receive that quantity. For example, if you take one (1) tablet per day, your *physician* must write a prescription for ninety (90) tablets. If you take two (2) tablets per day, your *physician* must write a prescription for one hundred and eighty (180) tablets. If your *physician* authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your *physician* to prescribe the normal supply, plus refills whenever appropriate.

There will be times when you need a prescription immediately. On these occasions, you should have your prescription filled at a local pharmacy using your Prescription Drug card. If you need medication immediately but will be taking it on an ongoing basis, ask your *physician* for two (2) prescriptions. The first should be for up to a thirty (30) day supply that you can have filled at a local pharmacy; the second prescription should be for the balance, up to a ninety (90) day supply. Send the larger prescription through the mail service prescription drug program.

NOTE: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgement of the pharmacist.

ARTICLE VI -- COORDINATION OF BENEFITS (COB)

A. General Provisions

When you and/or your dependents are covered under more than one (1) group health plan, the combined benefits payable by this Plan and all other group plans will not exceed one hundred percent (100%) of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan. Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When this Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining expenses, not to exceed normal Plan liability.

B. Automobile Coverage

Benefits payable under this Plan will be coordinated with benefits provided or required by any no-fault automobile coverage statute, whether or not a no-fault policy is in effect, and/or any other automobile coverage. This Plan will be secondary to any state mandated automobile coverage for services and supplies eligible for consideration under this Plan.

C. Federal Programs

The term "group health plan" includes the Federal programs *Medicare* and *Medicaid*. The regulations governing these programs take precedence over the order of determination of this Plan.

D. Health Maintenance Organizations (HMO)

In the case of HMO or other in-network only plans, this Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the covered person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the covered person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

E. Order of Benefit Determination – Employee / Spouse

When all other group health plans covering you and/or your spouse contain a coordination of benefits provision, order of payment will be as follows:

1. The plan covering a person as an active employee will be primary over a plan covering the same person as a dependent, a retiree, a laid-off individual or in some other capacity.
2. When a person is an active employee under more than one (1) plan, the plan covering the individual for the longer period of time will be considered primary.
3. The plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage (COBRA).

F. Order of Benefit Determination – Children

The group health plan covering an individual as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:

1. The plan covering the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses will be considered primary.
2. In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.
3. In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.
4. If there is a court decree stating that both parents share joint custody, without stipulating that one of the parents is responsible for the child's health care expenses, the Birthday Rule will be used to determine the order in which benefits are considered.

G. Order of Benefit Determination - Medicare

If you are entitled to *Medicare* for any reason but chose not to enroll under *Medicare* Parts A and B when entitled, this Plan will process your claims as though *Medicare* Parts A and B had been elected. If the Plan determines that *Medicare* would have been the primary payor, if enrolled, this plan will calculate the amount that Traditional *Medicare* Parts A and B would have paid and coordinate benefits accordingly.

Many factors determine whether this Plan or *Medicare* is the secondary payor for you and your spouse including the number of people employed by your *employer* and disabling *illness* for which an individual is treated. This plan does not discriminate against *Medicare* beneficiaries for whom *Medicare* is the secondary payer. This Plan will not coordinate benefits for prescription drugs for an individual enrolled in a *Medicare* D plan. If you or your dependent enrolls in a *Medicare* D plan, benefits available under this Prescription Drug Plan will be terminated – such termination may result in termination of all Plan coverage.

If you are entitled to *Medicare* and remain actively at work (for an employer which employs more than 20 employees) you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or you may designate *Medicare* as the exclusive payor of benefits. If you choose *Medicare* as the exclusive payor of benefits, coverage under this Plan will end. If you do not specifically choose *Medicare* as the exclusive payor of benefits, this Plan will continue to be primary. If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

H. Right To Make Payments To Other Organizations

Whenever payments which should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision.

Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

ARTICLE VII -- SUBROGATION

This Plan will be reimbursed 100% of any amounts paid whenever another party or parties is legally responsible or agrees to pay money due to an *illness* or *injury* suffered by you or your dependent(s).

Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan, without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

Acceptance of benefits under this Plan is constructive notice of this provision in its entirety and that you, your covered dependent, your representative, your covered dependent's representative or anyone else agrees:

1. That you will notify the Plan Administrator of any settlement with such third party and notify the Plan Administrator of any lawsuit filed by you or on your behalf against such third party, as well as providing the name and address of that party's insurance carrier.
2. To fully cooperate with the terms and conditions of this Plan. If you or your covered dependent choose not to act to recover money from any source, the Plan Administrator reserves the right to initiate its own direct action to obtain reimbursement.
3. That the benefits paid or to be paid by this Plan will be secondary, not primary.
4. That reimbursement to this plan will be 100% of amounts paid without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.
5. That reimbursement to this plan will be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency.
6. That you or any attorney that is retained by you will not assert the Common Fund or Made-Whole Doctrine;
7. That any amount recovered by a dependent minor or on behalf of a dependent minor by a trustee, guardian, parent or other representative of the minor shall be reimbursed to the Plan regardless of whether the minor's representative has access or control of any recovery funds.
8. To sign any documents requested by the Plan Administrator, or any representative of the Plan Administrator including but not limited to reimbursement and/or subrogation agreements. In addition, you agree to furnish any other information that might be requested by the Plan Administrator or representative of the Plan Administrator. Failure or refusal to execute such agreements or furnish information does not preclude the Plan Administrator or any representative of the Plan Administrator from exercising its right to subrogation or obtaining full reimbursement.

9. To take no action which will, in any way, prejudice the rights of the Plan. (If it becomes necessary for the Plan Administrator or any representative of the Plan Administrator to enforce this provision by initiating any action against you, your covered dependent, your representative, your covered dependent's representative or anyone else, you will be responsible to pay the fees of the Plan Administrator's attorney and all costs associated with the action regardless of the outcome of the action.)

The Plan shall have no obligation whatsoever to pay benefits to a covered person if a covered person refuses to cooperate with the Plan's reimbursement and subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and subrogation rights. Furthermore, in the event the covered person is a minor, the Plan shall have no obligation to pay any benefits incurred on account of injury or illness caused by a responsible third party until after the covered person or the authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and subrogation rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Recovery from Another Plan under which the Covered Person is Covered. This right of refund also applies when a covered person recovers under an uninsured or underinsured motorist plan (which will be treated as third party coverage when reimbursement or subrogation is in order), homeowners plan, renters plan, medical malpractice plan or any liability plan.

Uninsured and Underinsured Motorist Coverage. The plan has the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy or similar type of insurance or contract.

The amount of reimbursement that the Plan is entitled to receive under this provision is the amount in excess of the amount the employee received from all insurance sources which fully compensates he or she for all damages arising from the accidental injury for which such benefits have been paid.

Limitations of Liability. Neither plan administrator, the utilization review administrator, nor the claims administrator shall be liable for any of the following:

1. Situations such as epidemics, disasters, or other causes or conditions beyond their control that prevent enrollees from obtaining the benefits of this contract.
2. The quality of service or supplies received by enrollees, or the regulation of the amounts charged by any provider, since all those who provide care do so as independent contractors.
3. Harm that comes to an enrollee while in a provider's care.
4. Amounts in excess of the actual cost of services and supplies.

5. Amounts in excess of this program's maximums. This includes recovery under any claim of breach.
6. General damages including, without limitation, alleged pain, suffering or mental anguish.
7. Inaccurate and unapproved descriptive materials. The plan administrator will indemnify, defend and hold the claims administrator harmless from any claims, damages, judgments and expenses (including attorney's fees) based on or arising out of, directly or indirectly, descriptive materials written, created, designed or printed by any third party when such descriptive materials are used without the plan administrator's prior review and written approval and inaccurately reflect any of the terms, conditions and/or provisions of this contract.

The term "descriptive materials" includes, without limitation, any type of circular, leaflet, booklet, summary, handbook, letter or from that describes in whole or in part any of the terms, conditions and/or provisions of this contract.

Right To and Payment of Benefits. All rights to the benefits of this program are available only to enrollees. The Plan will not honor any attempted assignment, garnishment, attachment or transfer of any right of this program.

At its option and in accordance with the laws of the state in which the plan document was issued, the Plan may pay the benefits of this program to the employee, provider, other carrier, or other party legally entitled to such payment under federal or state qualified medical child support laws or jointly to any of these. Such payment will discharge the Plan's obligation to the extent of the amount paid so that the Plan will not be liable to anyone aggrieved by its choice of payee.

Any claims related to the accident or *illness* made after satisfaction of this obligation shall be the responsibility of the covered person, not the Plan.

Enrollee Cooperation. All enrollees are under a duty to cooperate in a timely and appropriate manner with the claims administrator in the administration of benefits or in the event of a lawsuit.

Evidence of Medical Necessity. The Plan has the right to require proof of medical necessity from the employee or a provider when he or she is receiving benefits under this program. No benefits will be available under this program if the proof is not provided or not acceptable to the Plan.

False or Misleading Statements. If this program's benefits are paid in error due to any false or misleading statements, the Plan will be entitled to recover these amounts.

Venue. All suits or legal proceedings brought against the Plan or the claims administrator by the employee or anyone claiming any right under this program must be filed within fifteen (15) months of the date the Plan denied, in writing, the rights or benefits claimed under this program or the state in which the employee resides or is employed.

Conformity Federal Regulations. In the event that any provision contained in the contract, benefit booklet, or any addendum attached thereto, is found to be in conflict with applicable laws or regulations, the conditions and provisions described therein, shall be construed and applied in compliance with such laws and regulations.

No Verbal Modifications. The enrollee shall not rely on any oral statement from an employee of the plan administrator or claims administrator. This includes, but is not limited to, a customer service representative:

1. modifying or otherwise affecting the benefits, general limitations, exclusions, or other provisions of the Plan; or
2. increasing, reducing, waiving or voiding any coverage's or benefits under the Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under the Plan.

Any written or oral verification received from the plan administrator or claims administrator is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to an enrollee.

ARTICLE VIII -- OTHER IMPORTANT PLAN PROVISIONS

A. Assignment Of Benefits

All benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment.

B. Special Election For Employees Age Sixty-Five (65) And Over

If you remain actively at work after reaching age sixty-five (65), you or your spouse may choose to remain covered under this Plan without reduction in *Medicare* benefits or designate *Medicare* as the exclusive payor of benefits. **If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits and *Medicare* will be secondary.** If you choose *Medicare* as primary, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you are under age sixty-five (65) and your spouse is over age sixty-five (65), he or she can make their own choice.

C. Medicaid-Eligible Employees And Dependents

If you or your dependents are Medicaid-eligible, you will be entitled to the same coverage under the Plan as all other employees and dependents. The benefits of this Plan will be primary to those payable through Medicaid.

D. Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover excess payments from any individual (including yourself), insurance company, or other organization to whom the excess payments were made or to withhold payment on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the Plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

E. Right To Receive And Release Necessary Information

The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions.

F. Alternate Payee Provision

Under normal conditions, benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment.

The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

G. Blue Card Pricing Disclosure

When you obtain health care services from a participating provider outside the geographic area Blue Shield of California serves, the amount you pay for covered services is calculated on either:

- The billed charges for your covered services, or
- The negotiated price that the on-site BlueCross and/or BlueShield Licensee (“Host Blue”) passes on to us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price considered by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payments arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices, however, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes

mandate Participant liability calculation methods that differ from the usual Blue Card method noted above in paragraph one of this Exhibit or require a surcharge, Blue Shield of California would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area Blue Shield of California serves, if this plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area Blue Shield of California serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area Blue Shield of California serves. But in no event will you be entitled to benefits for health care services, whenever you receive them, which are specifically excluded or limited from coverage by this plan.

H. Severability

The provisions of this Plan will be considered severable; therefore, if a provision is deemed invalid or unenforceable, that decision will not affect the validity and enforceability of the other provisions of the Plan.

ARTICLE IX -- CLAIM SUBMISSION PROCESS

A. What Is A Claim For Benefits

Pre-Service Claims:

Pre-service claims are claims for which advance approval is required. Pre-service claims may be submitted by telephone or in writing.

Refer to your medical ID card for contact information.

Post-Service Claims:

A post-service claim is defined as any request for Plan benefits that complies with the Plan's procedure for making a claim for benefits. A participating *health care provider* will submit a claim directly to the Plan on your behalf. If you desire Plan benefits, you must submit a claim when services are rendered by a *health care provider* that does not participate in the network.

A claim for benefits includes:

1. Employee information: name, address, plan name, group number.
2. Patient information: patient name, address, birth date.
3. Treatment information: date(s) of service, procedure code, description of each supply or service, diagnosis code, charge for each supply or service.
4. *Health care provider* information: name, address, telephone number, federal tax identification number.

Send the complete claim for benefits to the address indicated on your ID card.

The *plan administrator* will determine if enough information has been submitted to enable proper consideration of the claim for benefits. If not, more information may be requested from the claimant.

The *plan administrator* reserves the right to have a Plan participant seek a second medical opinion.

B. When A Claim For Benefits Should Be Filed

Pre-Service Claim:

When precertification of a claim is required, you should follow the procedures outlined in the Health Care Management Program article of this Plan.

If you desire a predetermination of plan benefits, you should notify the *Claims Administrator* at least fifteen (15) calendar days prior to receiving services.

Post-Service Claims:

A claim for benefits should be filed within ninety (90) days of the date charges for the service were incurred or within thirty (30) days after the service is completed. A claim for benefits filed after that date may be declined or reduced unless:

1. It is not reasonably possible to submit the claim within twelve (12) months of the date of service; and
2. The claim is submitted within one (1) year from the date incurred. This one-year period will not apply when the claimant is not legally capable of submitting the claim.

C. Claim For Benefits Procedure

There are different kinds of claim for benefits and each one has a specific timetable for approval, payment, request for further information, or denial. The period of time begins on the date the claim is filed. The following is a summary of the maximum response times allowed for each type of claim.

Pre-Service Urgent Care Claims

Notice to claimant of:

Insufficient information on the claim for benefits	24 hours
Extension for claimant to provide required information	48 hours
Benefit determination	72 hours

Pre-Service Non-Urgent Care Claims

Notice to claimant of:

Insufficient information on the claim for benefits	5 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination	15 calendar days

Post-Service Claims

Notice to claimant of:

Benefit determination (all required information received)	30 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination (requested information provided)	15 calendar days

D. Notice To Claimant Of Adverse Benefit Determination

The *plan administrator* shall provide written or electronic notice of any adverse benefit determination. The notice will state the following:

1. The specific reason(s) for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional information necessary for the claimant to perfect the claim for benefits, and an explanation of why such material or information is necessary.
4. A description of the Plan's appeal procedures, including a statement of the claimant's right to bring a civil action under section 502 of ERISA.
5. A statement that upon request, the claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. A statement that other voluntary dispute resolution options are available, such as mediation.

If the adverse benefit determination was based on an internal guideline, protocol, or other similar criterion, the specific guideline, protocol, or criterion will be provided. If this is not practical, a statement will be included that such a guideline, protocol, or criterion was relied upon in making the adverse benefit determination, and a copy will be provided free of charge to the claimant upon request.

If the adverse benefit determination is based on the medical necessity, experimental, or investigational exclusions of the Plan, an explanation of the clinical judgment for the determination will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

E. First Level Internal Appeal

You or your authorized representative may appeal an adverse benefit determination. Upon request, the *Claims Administrator* will complete a full and fair review. When a claimant receives an adverse benefit determination for a claim, the claimant has 180 days following receipt of the notification to appeal the decision. Otherwise, the initial adverse benefit determination shall be the final decision of the Plan.

When a claimant receives an adverse benefit determination for a pre-service claim, a grievance can be filed with the *Claims Administrator* orally or in writing. A grievance for a post-service claim must be submitted in writing.

This Plan provides for two levels of internal appeals. If the adverse benefit determination is partially or fully upheld, a claimant may appeal the initial appeal decision. If the benefit determination is partially or fully upheld upon second appeal, a claimant may appeal under the external review provisions of this Plan. The following is a summary of the maximum response times allowed for each type of claim appeal.

Pre-Service Urgent Care Claims

Initial internal appeal	24 hours for phone response (written response within 3 business days of phone response)
Second internal appeal	24 hours for phone response (written response within 3 business days of phone response)

Pre-Service Non-Urgent Care Claims

Initial internal appeal	15 calendar days
Second internal appeal	15 calendar days

Post-Service Claims

Initial internal appeal	30 calendar days
Second internal appeal	30 calendar days

The period of time within which the Plan must make a benefit determination for an appeal begins at the time an appeal is filed in accordance with the procedures of the Plan. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any appeal is pending.

For any appeal, a claimant may submit written comments, documents, records, and other information related to the claim for benefits. If the claimant requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

A document, record, or other information shall be considered relevant to a claim for benefits if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination;
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure that benefit determinations are made in accordance with Plan documents, and that Plan provisions have been applied consistently with respect to all claimants; or
4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Any review shall take into account all information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination, and will be conducted by a Plan representative who is neither the individual who made the adverse determination nor a subordinate of that individual. The *Claims Administrator* may hold a hearing of all parties involved, if the *Claims Administrator* deems such hearing to be necessary.

If the determination was based on a medical judgment, including determinations with regard to whether a particular service or supply is experimental, investigational, or not medically necessary or appropriate, the representative of the Plan will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the applicable field of medicine. Additionally, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination.

A written explanation of a claim appeal determination will include the following information:

1. The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;
2. Reference to Plan provisions and records on which the decision is based;
3. A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and
4. A statement regarding the Participant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal.

No action at law or in equity can be brought to recover under this Plan after the expiration of three years after the claim has been filed with the *plan administrator*.

F. Second Level External Review

You may file a request for an external review by an independent review organization (IRO) no later than four months following the date you receive a notice of an adverse benefit determination or final internal adverse benefit determination.

Within five business days following receipt of your external review request, the *Claims Administrator* must complete a preliminary review of your request. If the appeal is granted, the *Claims Administrator* must assign an IRO to conduct the external review and will submit all information to the IRO.

Within one business day following the preliminary review, the *Claims Administrator* must issue a written notification to you indicating the status of your request. If additional information is required, the written notification will include a description of the material or information necessary for you to perfect your external review request within the four-month filing period.

Upon receipt of the material or information requested, the *Claims Administrator* will review the information and forward it to the IRO within one business day. If, upon receipt of this information, the *Claims Administrator* reverses the internal adverse benefit determination, the *Claims Administrator* must send written notification to the IRO and to you within one business day after making such a decision. The assigned IRO must terminate the external review upon receipt of the notice from the *Claims Administrator*.

For any other appeal not reversed by the *Claims Administrator*, the IRO must provide written notice of the final external review decision within 45 days after receipt of the request for external review. The IRO must deliver this final notice to you and the *Claims Administrator*. The decision of the IRO shall be the final decision of the Plan.

The IRO will conduct their review and will not be bound by any decisions or conclusions previously reached by the *Claims Administrator*.

G. Second Level Expedited External Review

The external review process will be expedited if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

2. The internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service which you received on an emergency basis, but have not yet been discharged from a facility.

Upon receipt of your request for expedited external review, the *Claims Administrator* must immediately verify eligibility for external review, issue a notification in writing to you, and assign an IRO. The IRO is required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision within 48 hours after the date of providing that notice to you and the *Claims Administrator*.

H. Incurring A Claim For Benefits Outside The United States

If you incur expenses outside the United States, you must pay the provider directly and file a claim to be considered. The claim must be translated into English, and the charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount of U.S. dollars. Along with the claim, you must send a receipt showing that you paid the provider in full.

ARTICLE X -- FAMILY AND MEDICAL LEAVE ACT OF 1993

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

B. Reasons for FMLA Leave

You may continue to be covered under the Plan during an approved FMLA leave for one or more of the following reasons:

1. The birth of a son or daughter, in order to care for that son or daughter.
2. The placement of a son or daughter with you for adoption or foster care.
3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.
4. Because of a serious health condition that makes you unable to perform the functions of your position.
5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:
 - a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and
 - b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member's office, grade, rank, or rating.
6. A *qualifying exigency* due to your spouse, son, daughter, or parent's active duty status, or notification of an impending call to active duty status, in support of a contingency operation.

C. Serious Health Condition

For the purposes of Subsections 3. and 4., a serious health condition is defined as an *illness, injury, impairment, or physical or mental condition* that involves any period of incapacity or treatment as an *inpatient* in a *hospital, hospice, or residential medical care facility*; any period of incapacity requiring absence from work, school, or other regular daily activities of more than three (3) calendar days that also involves continuing treatment by or under the supervision of a *health care provider*; or continuing treatment by or under the supervision of a *health care provider* for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days; and for prenatal care. A *health care provider* means 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 others capable of providing health care services as defined by the Act.

D. Amount Of Leave

When an FMLA leave is taken in order to care for your spouse, son, daughter, or parent who has sustained a serious line-of-duty related health condition during service in the United States Armed Forces you may continue to be covered for up to twenty-six (26) weeks in a single twelve (12) consecutive month period. Any other approved FMLA leave is limited to twelve (12) weeks in any twelve (12) consecutive month period.

If you and your spouse are both employed by the *employer* the aggregate amount of FMLA leave may not exceed the maximum period described above in any twelve (12) consecutive months if such leave is taken for the birth of a son or daughter, the placement of a son or daughter with you for adoption or foster care, or in order to care for a parent who has a serious health condition. Your entitlement to leave for a birth or placement for adoption or foster care concludes at the end of the twelve (12) month period beginning on the date of the birth or placement.

E. Reduced Leave Schedule

Reduced leave schedule means a leave schedule that reduces the usual number of hours per week, or per day, that you are employed. Approved leave taken for reasons stated in Subsections 1. and 2. above cannot be taken intermittently or on a reduced leave schedule unless the *employer* and you agree otherwise. Approved leave described in Subsections 3. through 6. may be taken intermittently or on a reduced leave schedule when *medically necessary*.

F. Documentation And Procedures

The *employer* may require that leave taken for reasons stated in Subsections 3., 4., and 5 be supported by a certification letter issued by the treating *health care provider*, as appropriate. Military caregiver leave may require supporting certification from, or on behalf of the United States Department of Defense. If the validity of the certification is doubted, the *employer* can request that you obtain a second opinion, at the *employer's* expense, from a *health care provider* designated by the *employer*. If both certification letters are in conflict, the *employer* can request that you obtain, at the *employer's* expense, a third opinion from a provider jointly approved by you and the *employer*. The opinion of the third provider is binding.

You must notify the *employer* of your intention to take a FMLA leave at least thirty (30) days prior to the date the leave is to begin unless you prove that the need for the leave was not reasonably foreseeable. The *employer* may require you to substitute any existing paid leave, such as vacation leave, personal leave, or family leave, for any part of the unpaid FMLA leave.

Coverage will be continued during a FMLA leave at the same level and under the same conditions that coverage would have been provided if you had remained a member of the eligible group and covered under the Plan. Such continuation may be combined with any time allowed under the Extension of Coverage section of the Plan for coverage continuation in the event of a leave of absence or disability. If the *employer* provides a new health care plan of benefits, or changes health benefits or plans while you are on leave, you are entitled to the new or changed plan or benefits to the same extent as if you were not on leave. You will not be subject to the *waiting period* or the *pre-existing condition* limitation when restored to active service with the *employer* regardless of whether or not you chose to retain health coverage during FMLA leave. The *employer* reserves the right to deny restoration to certain Highly Compensated or Key Employees as determined by the conditions defined in the Act.

You must continue to make any required contribution to the Plan in order for coverage to continue. The *employer's* obligation to maintain health coverage under FMLA leave will cease if your contribution is more than thirty (30) days overdue. Failure to make the required contribution to the Plan will terminate coverage at the end of the period for which you made the last required contribution.

Further, failure to return from FMLA leave for reasons other than the continuation, recurrence, or onset of a serious health condition that entitles you to leave under FMLA, or other circumstances beyond your control, may result in the recovery, by the *employer*, of any contributions made by the *employer* toward the continuation of your coverage. When you fail to return from FMLA leave because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the *employer* from recovering any contribution made toward continuation of coverage, the *employer* may require a certification letter issued by your *health care provider* or the *health care provider* of your son, daughter, spouse or parent, as appropriate, verifying the *medical necessity* for continued leave. The certification letter must be submitted within thirty (30) days of the *employer's* request.

The amount that the *employer* may recover is limited to only the *employer's* share of allowable contributions as would be calculated under COBRA Continuation of Benefits excluding the two (2) percent fee for administrative costs. The *employer* may not recover any contributions for any period of FMLA leave covered by paid leave. The employee who returns to active service for at least thirty (30) calendar days is considered to have "returned to work."

The above is in compliance with the Family and Medical Leave Act of 1993, as amended, and the same as may be further amended from time to time.

ARTICLE XI -- COBRA CONTINUATION OF BENEFITS
(Consolidated Omnibus Budget Reconciliation Act)

A. Definitions

For purposes of this Continuation Coverage Under COBRA provision, the following definitions apply:

1. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
2. "Code" means the Internal Revenue Code of 1986, as amended.
3. "Continuation Coverage" means the Group Health Plan coverage elected by a qualified beneficiary under COBRA.
4. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.
5. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.
6. "Qualified Beneficiary" means:
 - a. A covered employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan;
 - b. A covered spouse or dependent who becomes eligible for coverage under the Plan due to a qualifying event, as defined below; or
 - c. A newborn or newly adopted child of a covered employee who is continuing coverage under COBRA.
7. "Qualifying Event" means the following events which, but for continuation coverage, would result in the loss of coverage of a qualified beneficiary:
 - a. Termination of a covered employee's employment (other than for gross misconduct) or reduction in his hours of employment;
 - b. The death of the covered employee;
 - c. The divorce or legal separation of the covered employee from his spouse;

- d. A child ceasing to be eligible as a dependent child under the terms of the group health plan; or
 - e. Your *employer* filing a Chapter 11 bankruptcy petition. Coverage may continue for covered retirees and/or their dependents if coverage ends or is substantially reduced within one year before or after the initial filing for bankruptcy.
8. “Totally Disabled” or “Total Disability” means totally disabled as determined under Title II or Title XVI of the Social Security Act.

B. Right To Elect Continuation Coverage

If a qualified beneficiary loses coverage under the group health plan due to a qualifying event, he may elect to continue coverage under the group health plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Entity. A qualified beneficiary must elect the coverage within the 60-day period beginning on the later of:

1. The date of the qualifying event; or
2. The date he was notified of his right to continue coverage.

If you are considered an eligible worker, in accordance with the Trade Adjustment Assistance Reform Act of 2002 (TAA), you may be entitled to elect COBRA continuation coverage during the 60-day period beginning on the first day of the month in which you begin receiving Trade Adjustment Assistance provided that the election is made within the six (6) month period immediately following the date of the TAA-related loss of coverage.

C. Notification Of Qualifying Event

If the qualifying event is divorce, legal separation or a dependent child’s ineligibility under a group health plan, the qualified beneficiary must notify the Entity of the qualifying event within sixty (60) days of the event in order for coverage to continue. You must report the qualifying event to the *plan administrator* in writing. The statement must include:

1. Your name;
2. Your identification number;
3. The dependent’s name;
4. The dependent’s last known address;

5. The date of the qualifying event; and
6. A description of the event.

In the case of a request for extension of the COBRA period as a result of a finding of disability by the Social Security Administration, you must also submit the disability determination. In addition, a totally disabled qualified beneficiary must notify the Entity in accordance with the section below entitled “Total Disability” in order for coverage to continue.

Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

D. Length Of Continuation Coverage

1. A qualified beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a covered employee may continue coverage under the group health plan for up to eighteen (18) months from the date of the qualifying event.
2. A qualified beneficiary who loses coverage due to the covered employee’s death, divorce, or legal separation, and dependent children who have become ineligible for coverage may continue coverage under the group health plan for up to thirty-six (36) months from the date of the qualifying event.

E. Total Disability

1. In the case of a qualified beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the “Act”) to have been totally disabled within sixty (60) days of a qualifying event (if the qualifying event is termination of employment or reduction in hours), that qualified beneficiary may continue coverage (including coverage for dependents who were covered under the continuation coverage) for a total of twenty-nine (29) months as long as the qualified beneficiary notifies the *employer*:
 - a. Prior to the end of eighteen (18) months of continuation coverage that he was disabled as of the date of the qualifying event; and
 - b. Within sixty (60) days of the determination of total disability under the Act.
2. The *employer* will charge the qualified beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this section.

3. If during the period of extended coverage for total disability (continuation coverage months 19-29) a qualified beneficiary is determined to be no longer totally disabled under the Act:
 - a. The qualified beneficiary shall notify the *employer* of this determination within thirty (30) days; and
 - b. Continuation coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the qualified beneficiary is no longer totally disabled.

F. Coordination Of Benefits

Benefits will be coordinated with any federal program, automobile coverage or group health plan in accordance with the provisions described in the Article entitled - Coordination of Benefits.

G. Termination Of Continuation Coverage

Continuation coverage will automatically end earlier than the applicable 18-, 29-, or 36-month period for a qualified beneficiary if:

1. The required monthly contribution for coverage is not received by the Entity within thirty (30) days following the date it is due;
2. The qualified beneficiary becomes covered under any other group health plan as an employee or otherwise. If the other group health plan contains an exclusion or limitation relating to a *pre-existing condition* (other than a *pre-existing condition* exclusion or limitation which the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996), and such exclusion or limitation applies to the qualified beneficiary, then the qualified beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the *pre-existing condition* applies to the qualified beneficiary (or, if sooner, until the expiration of the applicable 18-, 29- or 36-month COBRA period).
3. For totally disabled qualified beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such beneficiary is no longer totally disabled;
4. The qualified beneficiary becomes entitled to *Medicare* benefits; or
5. The Entity ceases to offer any group health plans.

H. Multiple Qualifying Events

If a qualified beneficiary is continuing coverage due to a qualifying event for which the maximum continuation coverage is eighteen (18) or twenty-nine (29) months, and a second qualifying event occurs during the 18- or 29- month period, the qualified beneficiary may elect, in accordance with the section entitled “Right To Elect Continuation Coverage”, to continue coverage under the group health plan for up to thirty-six (36) months from the date of the first qualifying event.

I. Continuation Coverage

The continuation coverage elected by a qualified beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the group health plan offered to similarly situated covered employees and their dependents. The continuation coverage is also subject to the rules and regulations under COBRA. If COBRA permits qualified beneficiaries to add dependents for continuation coverage, such dependents must meet the definition of dependent under the group health plan.

J. Carryover Of Deductibles And Plan Maximums

If continuation coverage under the group health plan is elected by a qualified beneficiary under COBRA, expenses already credited to the Plan’s applicable deductible and co-payment features for the year will be carried forward into the continuation coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will be carried forward into the continuation coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

K. Payment Of Premium

1. The group health plan will determine the amount of premium to be charged for continuation coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.
 - a. The group health plan may require a qualified beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

The American Recovery Reinvestment Act of 2009 (ARRA) temporarily provides federally subsidized COBRA premium assistance in the amount of 65%. This provision applies to those who were involuntarily terminated during the period as defined by ARRA.

- b. For qualified beneficiaries whose coverage is continued pursuant to the section entitled “Total Disability” of this provision, the group health plan may require the qualified beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for continuation coverage months 19-29.
 - c. Contributions for coverage may, at the election of the qualified beneficiary, be paid in monthly installments.
2. If continuation coverage is elected, the monthly contribution for coverage for those months up to and including the month in which election is made must be made within forty-five (45) days of the date of election.
 3. Without further notice from the Entity, the qualified beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Entity within thirty (30) days of the payment’s due date, continuation coverage will terminate in accordance with the section entitled “Termination of Continuation Coverage”, Subsection A. This 30-day grace period does not apply to the first contribution required under Subsection B.
 4. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the qualified beneficiary.

ARTICLE XII -- PROTECTED HEALTH INFORMATION

This Employee Benefit Plan collects and maintains a great deal of personal health information about you and your enrolled dependents. Federal HIPAA regulations on privacy and confidentiality limit how an Employee Health Plan and its *Plan Administrator* may use and disclose this information. This Article describes provisions that protect the privacy and confidentiality of your personal health information and complies with applicable federal law.

A. Definitions

For purposes of this Article, the following terms shall have the meaning set forth below unless otherwise provided by the Plan:

1. “Electronic Protected Health Information” means Protected Health Information that is transmitted or maintained in any electronic media.
2. “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.
3. “Member” means a covered employee or the covered dependents of a covered employee.
4. “*Plan Sponsor*” is San Joaquin Valley Insurance Authority.
5. “Plan” is City of Tulare Employee Benefit Plan.
6. “Plan Documents” means the group health plan’s governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the City of Tulare Plan Document.
7. “Protected Health Information” means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify a member. Protected Health Information includes information of persons living or deceased. The following components of a member’s information also are considered Protected Health Information:
 - a. Names;
 - b. Street address, city, county, precinct, zip code;
 - c. Dates directly related to a member, including birth date, health facility admission and discharge date, and date of death;

- d. Telephone numbers, fax numbers, and electronic mail addresses;
 - e. Social Security numbers;
 - f. Medical record numbers;
 - g. Health plan beneficiary numbers;
 - h. Account numbers;
 - i. Certificate/license numbers;
 - j. Vehicle identifiers and serial numbers, including license plate numbers;
 - k. Device identifiers and serial numbers;
 - l. Web universal resource locators (URLs);
 - m. Biometric identifiers, including finger and voice prints;
 - n. Full face photographic images and any comparable images; and
 - o. Any other unique identifying number, characteristic, or code.
8. "Regulation" means the Health Insurance Portability and Accountability Act of 1996, as amended.
9. "Security Incidents" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. The Plan Sponsor will report a successful Security Incident to the Plan within a reasonable period of time after learning of the successful security incident. Data relating to an unsuccessful attempt may be aggregated and reported to the Plan on a less frequent basis.
10. "Summary Health Information" means information that may be individually identifiable health information, and
- a. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
 - b. From which the information described in the regulation has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

B. Permitted And Required Uses And Disclosure Of Protected Health Information

Subject to obtaining written certification, this Plan may disclose Protected Health Information to the *Plan Sponsor*, provided the *Plan Sponsor* does not use or disclose such Protected Health Information except for the following purposes:

1. Performing Plan administrative functions which the *Plan Sponsor* performs for the Plan.
2. Obtaining bids for providing employee coverage under this Plan; or
3. Modifying, amending, or terminating the Plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the *Plan Sponsor* be permitted to use or disclose Protected Health Information in a manner that is inconsistent with the regulation.

C. Conditions Of Disclosure

The Plan, or any employee coverage with respect to the Plan, shall not disclose Protected Health Information to the *Plan Sponsor* unless the *Plan Sponsor* agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to Protected Health Information.
3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the *Plan Sponsor*.
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with the Regulation.
6. Make available to a Plan participant who requests an amendment to the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the Regulation.
7. Make available to a Plan participant who requests an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with the Regulation.

8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Regulation.
9. If feasible, return or destroy all Protected Health Information received from the Plan that the *Plan Sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the 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 information feasible.
10. Ensure that the adequate separation between the Plan and the *Plan Sponsor* required in the Regulation is satisfied.

D. Certification Of Plan Sponsor

The Plan shall disclose Protected Health Information to the *Plan Sponsor* only upon the receipt of a certification by the *Plan Sponsor* that the Plan has been amended to incorporate the provisions of the Regulation, and that the *Plan Sponsor* agrees to the conditions of disclosure set forth in Item C. above.

E. Permitted Uses And Disclosure Of Summary Health Information

The Plan may disclose Summary Health Information to the *Plan Sponsor*, provided such Summary Health Information is only used by the *Plan Sponsor* for the purpose of:

1. Obtaining bids for providing employee coverage under this Plan; or
2. Modifying, amending, or terminating the Plan.

F. Permitted Uses And Disclosure Of Enrollment And Disenrollment Information

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the *Plan Sponsor*, provided such enrollment and disenrollment information is only used by the *Plan Sponsor* for the purpose of performing administrative functions that the *Plan Sponsor* performs for the Plan.

G. Adequate Separation Between The Plan And The Plan Sponsor

The *Plan Sponsor* shall limit access to Protected Health Information to only those employees authorized by the *Plan Sponsor*. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that

the *Plan Sponsor* performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the *Plan Sponsor* for non-compliance pursuant to the *Plan Sponsor's* employee discipline and termination procedures.

H. Security Standards For Electronic Protected Health Information

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the *Plan Sponsor* shall reasonably safeguard the Electronic Protected Health Information as follows:

1. *Plan Sponsor* shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that *Plan Sponsor* creates, receives, maintains, or transmits on behalf of the Plan;
2. *Plan Sponsor* shall ensure that the adequate separation that is required by the Regulation is supported by reasonable and appropriate security measures;
3. *Plan Sponsor* shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. *Plan Sponsor* shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. *Plan Sponsor* shall report to the Plan within a reasonable time after *Plan Sponsor* becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - b. *Plan Sponsor* shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

This Plan will comply with the requirement of 45 C.F.R. / 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164.

ARTICLE XIII -- DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Medical Expenses.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Approved Clinical Trial

A clinical trial that is conducted in relation to treatment of cancer or other life-threatening disease or condition that is:

1. A federally funded trial approved or funded by one or more of the following:
 - a. The National Institutes of Health (NIH).
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare and Medicaid Services.
 - e. Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veteran Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - g. The Department of Defense, the Department of Energy, or the Department of Veteran Affairs if 1) the study has been approved through a system of peer review determined to be comparable to the system used by NIH and 2) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. A study or investigation that is a drug trial that is exempt from having such an investigational new drug application.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing *birthing center* requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: A facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate post partum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified *nurse* midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers, and maintain medical records on each patient and child.

Calendar Year

The 12-month period beginning January 1 and ending December 31.

Claims Administrator

HealthNow Administrative Services.

Cosmetic Surgery

A procedure performed primarily to improve appearance which does not meaningfully promote the proper function of the body or prevent or treat an *illness, injury* or disease.

Creditable Coverage

Coverages required to be included as such under Section 701(c) of ERISA, and shall exclude those coverages that are permitted to be excluded under Section 701(c) of ERISA. Solely for purposes of illustration and not in limitation of the foregoing, *creditable coverage* generally includes periods of coverage under an individual or group health plan (including *Medicare*, Medicaid, governmental and church plans) that are not followed by a *significant break in coverage* and excludes coverage for liability, limited scope dental or vision benefits, specified disease and/or other supplemental-type benefits. **Days in a *waiting period* are not *creditable coverage*.**

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Dental Care Provider

A *dentist, dental hygienist, physician, or nurse* as those terms are specifically defined in this section.

Dental Hygienist

A person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed *dentist*.

Dentist

A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Charges

The *usual and customary charges* for x-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Domestic Partner

An individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring; and
2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least sixty-two (62) years old and is eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Durable Medical Equipment

Equipment able to withstand repeated use for the therapeutic treatment of an active *illness or injury*. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an *illness or injury* and could be purchased without a *physician's* prescription.

Employer

City of Tulare.

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Experimental/Investigational

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue.

Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Experimental/investigational items and services are not covered under this plan unless identified as a covered service elsewhere in this Plan.

General Anesthesia

An agent introduced into the body which produces a condition of loss of consciousness.

Genetic Information

The information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Care Provider

A *physician, practitioner, nurse, hospital or specialized treatment facility* as those terms are specifically defined in this section.

Home Health Care Agency

An agency or organization that provides a program of home health care and that:

1. is approved as a *home health care agency* under *Medicare*;
2. 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 responsibility for licensing under the law; or

3. meets all of the following requirements:
 - a. 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;
 - b. it has a full-time administrator;
 - c. it maintains written records of services provided to the patient;
 - d. its staff includes at least one registered *nurse* or it has nursing care by a registered *nurse* available; and
 - e. its employees are bonded and it provides malpractice and malplacement insurance.

Hospice Care

A program approved by the attending *physician* for care rendered in the home, *outpatient* setting or institutional facility to a terminally ill covered person with a medical prognosis that life expectancy is six (6) months or less.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less.

The facility must have an interdisciplinary medical team consisting of at least one (1) *physician*, one (1) registered *nurse*, one (1) social worker, one (1) volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital

The term *hospital* means:

1. an institution constituted, licensed, and operated in accordance with the laws pertaining to *hospitals*, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *injury* or *illness*, and which provides such treatment for compensation, by or under the supervision of *physicians* on an *inpatient* basis with continuous 24-hour nursing service by registered *nurses*;
2. an institution which qualifies as a *hospital* and a provider of services under *Medicare*, and is accredited as a *hospital* by the Joint Commission on the Accreditation of Health Care Organizations;

3. a *rehabilitation facility*.

The term *hospital* shall also include a *residential treatment* facility specializing in the care and treatment of mental health conditions or substance abuse treatment, provided such facility is duly licensed if licensing is required, or otherwise lawfully operated if licensing is not required.

Regardless of any other Plan provision or definition, the term *hospital* will not include an institution which is other than incidentally, a place of rest, place for the aged or a nursing home.

Illness

Any bodily sickness, disease or mental health disorder. For the purposes of this Plan, pregnancy will be considered an *illness*.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or accident.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward, or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purposes of providing normal post-operative recovery treatment or service.

Late Enrollee

An individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime

The period of time you or your eligible dependents participate in this Plan.

Maintenance Care

Services and supplies primarily to maintain a level of physical or mental function.

Medical Emergency

An *illness* or *injury* which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible *hospital* equipped to furnish care to prevent the death or serious impairment of the covered person.

Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsion, or such other acute medical conditions as determined to be *medical emergencies* by the *Plan Administrator*.

Medically Necessary (Medical Necessity)

Any service or supply required for the diagnosis or treatment of an active *illness* or *injury* that is rendered by or under the direct supervision of the attending *physician*, generally accepted by medical professionals in the United States and non-experimental.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Morbid Obesity

A condition in which the body weight exceeds the normal weight by either 100 pounds, or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate *Nurse* (R.N.), Licensed Vocational *Nurse* (L.V.N.) or Licensed Practical *Nurse* (L.P.N.).

Open Enrollment Period

A pre-determined and pre-announced period of time each year to enroll in coverage, change or discontinue coverage.

Oral Surgery

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Outpatient

Treatment either outside a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Partial Hospitalization Treatment Facility

A public or private facility, licensed and operated according to the law, which provides intensive therapy daily by a *physician* and licensed mutual *health care providers* (five (5) days per week for no more than eight (8) hours per day). No room and board charges are incurred. This facility does not provide a place for rest, the aged or convalescent care.

Physically or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as, but not limited to, mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition preventing the individual from being self-sufficient or other *illness* as approved by the *Plan Administrator*.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The *Plan Administrator*, San Joaquin Valley Insurance Authority, is the sole fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of the Plan assets. The *Plan Administrator* shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan.

The *Plan Administrator* has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan participant or beneficiary.

The *Plan Administrator* may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be a fiduciary of the Plan and will not exercise any other discretionary authority and responsibility granted to the *Plan Administrator*, as described above.

Plan Sponsor

San Joaquin Valley Insurance Authority.

Plan Year

The 12-month period beginning January 1st and ending December 31st.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and/or holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist or Registered Respiratory Therapist.

Pre-Existing Condition

A *pre-existing condition* is a physical or mental condition, regardless of the cause of the condition from which medical advice, diagnosis, care or treatment was recommended or received within the three (3) month period ending on the person's *enrollment date*.

Professional Components

Services rendered by a professional technician (e.g. radiologist, pathologist, anesthesiologist) in conjunction with services rendered at a *hospital, ambulatory surgical center or physician's office*.

Qualified Medical Child Support Order

A medical child support order that either creates or recognizes the right of an alternate recipient (i.e., a child of a covered participant who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the Plan.

A "medical child support order" is a judgment, decree or order (including a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state, that provides for child support related to health benefits with respect to the child of a group health plan participant, or required health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or that enforces a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

Qualifying Exigency

An event arising from your spouse, son, daughter, or parent's call to active duty in the United States Armed Forces. Such exigencies are:

1. Short-Notice Deployment

Leave if your covered family member is notified of a deployment of seven days or less. You may take a leave of up to seven days for any reason related to that deployment. The seven day period begins on the day the covered family member is notified of the short-notice deployment.

2. Military Events

Leave in order to attend any official ceremony, program or event sponsored by the armed forces, and to attend family support and assistance programs and information briefings sponsored by the military, military service organizations, or the American Red Cross.

3. Child Care / School Activities

Leave in order to arrange for child care or attend certain school functions of the son or daughter of a covered military family member, including leave to:

- a. Arrange for alternative school or childcare;
- b. Provide childcare on an urgent, immediate need (not regular) basis;
- c. Enroll or transfer a child into a new school or day care facility; and
- d. Attend meetings with school or day care staff regarding discipline, parent-teacher conferences, and school counselors if directly related to the active duty of a covered military family member.

4. Financial And Legal Arrangements

Leave in order to make or update financial or legal arrangements to address the covered military family member's absence while on active duty/call to active duty, such as preparing or executing a will, powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, and securing military service benefits (Leave is not available for routine matters, such as paying bills.)

5. Counseling

Leave in order to attend counseling by a non-health care provider (i.e. military chaplain, pastor, or minister, or counseling offered by the military or a military service organization) available when counseling is needed by the employee, the covered military member, or the son or daughter of the covered military member provided that the counseling arises from active duty service or call to active duty.

6. Rest And Recuperation Leave

Leave in order to spend time with a covered military family member on rest and recuperation leave during a period of deployment. You may take a leave of up to five days during any military family member's rest and recuperation leave.

7. Post-Deployment Activities

Leave in order to attend ceremonies incident to the return of the covered military family member, including arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of ninety (90) days following the termination of the covered military member's active duty status, participation in Department of Defense "Yellow Ribbon Reintegration" Program (participation is permitted even if it exceeds the general ninety (90) day limitations period by a few days).

Additionally, such leave is available to address issues arising from the death of a covered military family member including meeting and recovering the body and making funeral arrangements.

8. Additional Activities

Upon approval by the *Plan Administrator*, any other activity arising from your covered family member's call to or active service duty/contingency operation in the United States Armed Forces.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part time care services, or an institution which primarily provides treatment of mental health conditions, substance abuse treatment or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitative*

facility for the treatment of medical conditions, mental health conditions or substance abuse treatment in the jurisdiction where it is located, or is credited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Respite Care

Respite care rendered through a licensed *hospice facility* for home custodial care which provides relief to an immediate family in caring for the day to day needs of a terminally ill individual.

Second/Third Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the diagnosis of the proposed *surgery* to evaluate alternatives and/or the medical advisability of undergoing a surgical procedure.

Significant Break In Coverage

A period of sixty-three (63) or more consecutive days without *creditable coverage*. Periods of no coverage during an HMO affiliation period or *waiting period* shall not be taken into account for purposes of determining whether a *significant break in coverage* has occurred. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

Skilled Nursing Facility/Extended Care Facility/Convalescent Nursing Hospital

An institution that:

1. primarily provides skilled (as opposed to custodial) nursing service to patients;
2. is approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAH) and/or *Medicare*.

In no event shall such term include any institution or part thereof that is used principally as a rest facility or facility for the aged or, any treatment facility for mental health condition or substance abuse treatment.

Special Enrollee

A Special Enrollee is an employee or dependent who is entitled to and who requests special enrollment:

1. within thirty-one (31) days of losing other health coverage because their COBRA coverage is exhausted, they cease to be eligible for other coverage, or employer contributions are terminated;
2. for a newly acquired dependent, within thirty-one (31) days of the marriage, birth, adoption, or placement for adoption; or
3. within sixty (60) days of losing other health coverage through Medicaid or CHIP.
4. for a *transitional rule dependent*, within thirty (30) days of receiving a written notification of the transitional rule.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this Plan include *birthing centers, ambulatory surgical facilities, hospice facilities, or skilled nursing facilities* as those terms are specifically defined.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Total Disability (Totally Disabled)

The inability to perform all the duties of the covered person's occupation as the result of an *illness* or *injury*. *Total disability* means the inability to perform the normal duties of a person of the same age.

Transitional Rule Dependent

A dependent child who was under the age of twenty-six (26) on July 1, 2012 and was previously:

1. enrolled in the plan and their eligibility was terminated due to age; or
2. not eligible under the plan when the employee first became eligible as the child's age at that time exceeded the Plan limitation.

Usual and Customary Charge

The charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other *physicians, practitioners or dentists*.

Waiting Period

A period of continuous, full-time employment before an employee or dependent is eligible to enroll in the Plan, or for purposes of determining *creditable coverage*, the *waiting period* under any other health plan.

Year

See *Plan year*.

ARTICLE XIV -- GENERAL INFORMATION

Name and Address of the Plan Sponsor

San Joaquin Valley Insurance Authority
2220 Tulare Street, Suite 1400
Fresno, CA 93721

Name and Address of the Plan Administrator

San Joaquin Valley Insurance Authority
2220 Tulare Street, Suite 1400
Fresno, CA 93721

Name and Address of the Person Designated as the Agent for Service of Legal Process

San Joaquin Valley Insurance Authority
2220 Tulare Street, Suite 1400
Fresno, CA 93721

Name, Address and Tax Identification Number of Participating Employers

City of Tulare
411 East Kern Avenue
Tulare, CA 93274
Tax ID: 94-6000443

Claims Administrator

HealthNow Administrative Services
P.O. Box 211034
Eagan MN 55121

Internal Revenue Service and Plan Identification Number

The corporate tax identification number for the San Joaquin Valley Insurance Authority as assigned by the Internal Revenue Service is 27-1557908. The plan number is 501.

Plan Year

The 12-month period beginning January 1st and ending December 31st.

Method of Funding Benefits

Except as provided below, this Plan shall be funded by the participating employer under the San Joaquin Valley Insurance Authority employee benefit plan. The *employer's* share of the required funding of this Plan shall be determined by the President (or other duly authorized officer) of the participating employer under the San Joaquin Valley Insurance Authority employee benefit plan.

As a condition of coverage under this Plan, you may be required to contribute to the Plan. The required amount of your contribution, if any, shall be communicated to you by the *plan administrator*. The *plan administrator* reserves the right to increase or decrease contributions from time to time.

All funding under this Plan, whether funded by the *employer* or by employee contribution, shall be transferred to the San Joaquin Valley Insurance Authority for the purposes of holding and administering the assets necessary to provide the benefits described in this Plan.

Plan Modification And Termination

The *Plan Administrator* intends to continue the Plan indefinitely. Nevertheless, San Joaquin Valley Insurance Authority reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of your coverage. The *Plan Administrator* will notify all covered persons as soon as possible, but in no event later than sixty (60) days after the effective date the plan change was adopted. Expenses incurred prior to the Plan termination, modification or amendment will be paid as provided under the terms of the Plan prior to its termination, modification or amendment.

Discretion of Plan Administrator

The *Plan Administrator* shall be the sole determiner of all matters concerning medical benefits and coverage under this Plan. The *Plan Administrator* shall have broad discretion in interpreting the provisions of this Plan, which discretion shall be exercised in good faith. The *Plan Administrator's* discretionary authority includes, but is not limited to, resolving questions of coverage and benefits, determining matters relating to eligibility, deciding questions of administration, and deciding other questions under the Plan.

SIGNATURE PAGE

The effective date of the San Joaquin Valley Insurance Authority Employee Benefit Plan is January 1, 2013.

It is agreed by the San Joaquin Valley Insurance Authority that the provisions of this document are correct and will be the basis for the administration of the San Joaquin Valley Insurance Authority Employee Benefit Plan.

Participating Entity

Dated this _____ day of _____, _____

BY: _____

TITLE: _____

WITNESS: _____

TITLE: _____

San Joaquin Valley Insurance Authority

Dated this _____ day of _____, _____

BY: _____

TITLE: _____

WITNESS: _____

TITLE: _____