ICSVEBA

Imperial County Schools Voluntary Employees Benefits Association

Summary Plan Description

Medical and Prescription Drug Benefits

Effective: October 1, 2010
Plan Year: October 1 – September 30

Participants
Calipatria Unified School District
El Centro Elementary School District
Heber Elementary School District
Imperial County Office of Education
Imperial Valley College
Imperial Valley ROP
Magnolia School District
McCabe Union School District
Meadows Union School District
Mulberry School District
San Pasqual Valley Unified School District
Seeley Union School District

The benefits described in this SPD are part of the Welfare Benefit Plan for Employees of Imperial County Schools Voluntary Employees Benefits Association. Note: ICSVEBA believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act), as described on the following page.
ICSVEBA is pleased to provide you with the following options for medical coverage:

- Basic
- Comprehensive
- Comprehensive Plus Frontera
- Catastrophic
- La Nueva Frontera
- Coordination of Benefits (COB)

If you enroll in one of the medical options listed above, you and your covered dependents can also take advantage of the:

- **Employee Assistance Program (EAP).** The EAP provides confidential, professional services to help cope with issues that threaten or disrupt your life at home or work.

- **Prescription Drug Benefits:** Coverage for both short-term and long-term medicines.  
  *Note: Not all plans cover prescription drugs.*

This Summary Plan Description (SPD) is divided into three sections:

- **Eligibility and Enrollment Information** explains how to enroll for benefits, your cost for coverage and when you can change your or your dependents’ coverage.

- **Description of Benefits** covers the major features of the medical and prescription benefit options, as well as important phone numbers and website addresses.

- **General Information** discusses how to apply for benefits, situations that may affect your benefits, how the plan operates and your legal rights under the Employee Retirement Income Security Act (ERISA).

Take time to read this material carefully and share it with your family. If you have any questions about your coverage, contact your Human Resources representative.

*Note: The standards for coverage of medical expenses change from time to time. You will receive periodic notices of important changes or modifications to the plan (to the extent that they are inconsistent with the benefits described in this SPD). However, all changes to covered benefits are binding.*

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**Grandfathered Health Plan**

ICSVEBA believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
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ELIGIBILITY

See the Extensions of Coverage section for instances when these eligibility requirements may be waived or modified. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Employees and Retirees
To be eligible to enroll as an Employee or a Retiree, an individual must meet the requirements outlined below (based upon the employer you receive benefits through):

- **Calipatria Unified School District**
  - A regular employee who is working on a full-time or part-time basis as a Management, Certificated or Classified employee, or a member of the Board of Trustees.
    - A full-time employee is one working at least 7 hours/day.
    - A part-time employee is one working at least 4 hours but less than 7 hours/day.
    - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.
  - A retiree who is at least 55 years of age, with a minimum of 10 years of continuous service with the District and who retired through the Public Employees' Retirement System (PERS) or through the State Teachers' Retirement System (STRS).
  - A former member of the Board of Trustees, pursuant to Government Code 53201, who satisfies all of the following conditions: (1) served in office after January 1, 1981, (2) whose term began before January 1, 1995, and (3) who served for 12 or more years.

- **El Centro Elementary School District**
  - A regular employee who is working on a full-time or part-time basis as a Management (Certificated and Classified) employee, a Classified employee (including but not limited to confidential), or a member of the Board of Trustees.
    - A full-time employee is one working at least 40 hours/week.
    - A part-time employee is one working at least 20 hours but less than 40 hours/week.
    - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.
  - A retiree who is:
    - a Classified employee or Classified Management employee who is at least 55 years of age, with a minimum of 10 years of continuous service with the District and who retired through the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS), or
    - a Management (Certificated and Classified) employee who retired through the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS).

- **Heber Elementary School District**
  - A regular employee who is working on a full-time or part-time basis as a Management, Certificated or Classified employee, or a member of the Board of Education.
    - A full-time employee is one working at least 40 hours/week.
    - A part-time employee is one working at least 30 hours/week and at least 6 hours/day.
    - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.
  - There is no retiree coverage.
**Imperial County Office of Education (ICOE)**

- A regular employee who is working on a full-time or part-time basis, or a member of the Board of Education.
  - A full-time employee is one working at 12 months/year.
  - A part-time employee is one working at least 10 months but less than 12 months/year.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

- A retiree who:
  - was a full-time Certificated employee (75-100%) at the time of retirement, is at least age 55 but less than 65 and: (1) was continuously employed by ICOE for 15 years prior to retirement, or (2) whose age plus years of service totals 70 or more. However, in no case shall a retiree be eligible for benefits without serving a minimum of 10 years of service for ICOE. Eligibility hereunder will extend to the retiree and eligible Dependent(s) but eligibility will not extend beyond the date the retiree attains age 65;
  - is a Classified employee who has completed 15 years of service and is receiving a pension according to the rules and regulations of the Employer's pension benefits program at the time of the retirement; or
  - is full-time Cabinet level, including the County Superintendent of Schools at the time of retirement at age 55 or older who has been employed by the Imperial County Office of Education, or has been employed at least 15 years as a California Public School Administrator at a school district or school site level or at any other County Office of Education including a minimum of 3 years employed by the Imperial County Office of Education at the Cabinet level.

**Imperial Valley College**

- A regular employee who is working on a full-time or part-time basis, or a member of the Imperial Community College District.
  - A full-time employee is one working at 12 months/year.
  - A part-time employee is one working at least 10 months but less than 12 months/year.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

  - For additional information about retiree coverage, contact your local Human Resources Department.

**Imperial Valley ROP**

- A regular employee who is working on a full-time or part-time basis.
  - A full-time employee is one working at least 30 hours/week.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

  - There is no retiree coverage.
Magnolia School District

- **Hired before July 1, 2005:** Magnolia School District pays the full cost of family coverage for the following employees:
  - Full-time certified staff member is defined as having a contract for 7 hours/day for at least 183 days.
  - Full-time classified instructional staff is defined as working at least 35 hours/week for 10 months.

- **Hired after July 1, 2005:** Magnolia School District pays the full cost of Employee Only coverage for the following employees (note: family coverage is available, at the employees cost):
  - Full-time classified non-instructional staff member is defined as working at least 40 hours/week for 12 months.
  - Part-time certified staff includes any certified staff that does not have a contract for at least 7 hours/day for at least 183 days.
  - Part-time classified staff includes any staff that does not meet the above definition for full-time status.
  - Regular Employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

- There is no retiree coverage.

McCabe Union School District

- A regular employee who is working on a full-time basis or a member of the Board of Education.
  - A full-time employee is one working at least 35 hours/week.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

- A retired Confidential Employee who:
  - Retires before age 65; and
  - Has at least twelve (12) years of service; and
  - Whose age, when added to the length of service in the District totals at least 75.

- A retired Superintendent who retired prior to October 1, 1993.

Meadows Union School District

- A regular employee who is working on a full-time basis as a Management, Certificated or Classified employee or on a part-time basis as a Classified employee.
  - A full-time employee is one working at least 30 hours/week.
  - A part-time employee is one working at least 5 hours but less than 6 hours/day.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

- A retiree who is a:
  - Non-Certificated (Classified) employee at least 55 years of age, with a minimum of 10 years of continuous service with the District and who retired through the Public Employees' Retirement System (PERS); or
  - Certificated employee who is at least 55 years of age, with a minimum of 15 years of service with the District, or a Certificated employee who is at least 60 years of age, with a minimum of 10 years of service with the District, and who is retired through the State Teachers' Retirement System (STRS); or
  - Management (Certificated and Classified) employee who retired through the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS).
**Mulberry School District**

- A regular employee who is working on a full-time basis,
  - A full-time employee is one working at least 30 hours/week.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

- An employee who is hired as the Superintendent/Principal.

- A retired Certified or Classified employee who:
  - Retires before age 65 and was a full-time employee prior to retirement; or
  - Has at least twelve (12) years of service with the District and whose age, when added to the length of service in the District, totals at least 75.

**San Pasqual Valley Unified School District**

- A regular employee who is:
  - Working on a full-time basis as a Management, Certified or Classified employee, or
  - Any part-time employee working greater than four hours/day and a minimum of 181 days/year.

- A retiree who is receiving a pension according to the rules and regulations of the Employer’s pension benefits program at the time of the retirement.

**Seeley Union School District:**

- A regular employee who is working on a full-time basis, a member of the Board of Education, and any part-time Certified employee who is not a member of the certified bargaining unit, who works less than a 7-hour day, and who has been specifically approved to receive benefits by the Board of Trustees through either policy or action.
  - A full-time employee is one working at least 6 hours/day.
  - Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

- A retiree who is:
  - Certified employee with a minimum of 15 years of continuous service and is receiving a pension according to the rules and regulations of the Employer’s pension benefits program at the time of the retirement; or
  - Classified employee who has completed 25 years of service and is receiving a pension according to the rules and regulations of the Employer’s pension benefits program at the time of retirement.

**Active Employment**

An Employee will be deemed in “active employment” on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

An Employee will also be deemed in “active employment” on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see “Non-Discrimination Due to Health Status” in the General Plan Information section). An exception applies only to an Employee’s first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.
Medicare
You and/or your dependent are eligible for Medicare:

- at age 65 or older if a citizen or permanent resident of the United States, or
- younger than age 65 if:
  o deemed permanently disabled and have been receiving Social Security or Railroad Retirement Board disability benefits for 24 months, or
  o diagnosed with End Stage Renal Disease.

If You Don't Enroll for Medicare
Benefits under this Plan will be reduced by the benefits to which you and/or your dependents receive (or should have received) if enrolled for Medicare Part A and Part B coverage. In addition, medical services that are not payable under Medicare, because your or your dependent fails to follow prescribed Medicare procedures, are not covered under this Plan.

Medicare Benefits
You are entitled to the following two types of Medicare benefits:

- Part A – Hospital Insurance: There is no premium for those that are eligible for Medicare. Benefits include:
  o hospitalization,
  o skilled nursing care,
  o home health care, and
  o hospice.

- Part B – Supplementary Medical Insurance: There is a premium for those that qualify; the amount is deducted from Social Security Checks for those that choose to enroll. Benefits include:
  o physician charges,
  o physical and speech therapy,
  o diagnostic tests,
  o durable medical equipment, and
  o outpatient care.

Enrollment
Individuals close to age 65 need to apply for Part A and Part B, unless he/she is already receiving Social Security or Railroad Retirement benefits. The initial enrollment period runs from the three (3) months prior to the 65th birthday until four months after the 65th birthday (a total of 7 months). If you do not enroll during that time, there is a general enrollment period from January 1 – March 31 each year, with the following effective dates:

- Part A is effective immediately upon enrollment.
- Part B is effective July 1 (the beginning of the Medicare Plan year). Note: A 10% penalty applies on the Part B premium for each year a person could have enrolled but did not.
Dependents
An eligible Dependent of an Employee or Retiree is:

- a legally married spouse. A "spouse" will mean a person of the opposite sex (i.e., not the same sex as the Employee). "Legally married" means a legal union (as defined by the Employee's/Retiree's state of residence) between one man and one woman as husband and wife;

- a domestic partner when both the partner and Employee/Retiree: (1) are of the same sex, (2) are at least eighteen years of age and mentally competent to consent to a contract, (2) are each other's sole domestic partner and intend to remain so indefinitely, (3) are not married to or legally separated from anyone else, (4) are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside, (5) are living together in the same residence and intend to do so indefinitely, (6) are engaged in a committed relationship of long standing, mutual care and support and are jointly responsible for each other's common welfare and living expenses. Domestic partnership certification will be subject to Plan Sponsor approval and the Plan Sponsor's decision will be final. If the domestic partnership ends or ceases to meet the above criteria, it is the Employee's responsibility to obtain and submit a notice of termination of coverage for a domestic partner within thirty (30) days. Any false, incorrect and/or misleading information in the application for domestic partnership can result in the loss of benefits and the cost of any benefits improperly paid based on false, incorrect or misleading information will be subject to the Plan's overpayment provisions. Employee must comply with the Internal Revenue Code and applicable regulations pertaining to the value of the benefits provided for a domestic partner;

- a child up to age 26. For these purposes a "child" will include:
  - a natural child;
  - a stepchild;
  - a child for whom Employee has been appointed legal guardian;
  - a foster child for whom Employee has assumed a legal obligation and where: (1) Employee is raising the child as his own and has assumed full parental responsibility for the child, (2) the child lives in the Employee's home and depends on the Employee for primary support, and (3) Employee legally claim the child as a federal income tax deduction. A foster child is not a child that is temporarily living in the Employee's home, who is placed with the Employee by a social service agency that retains control of the child, or whose natural parent may exercise or share parental responsibility and control;
  - a child who is adopted or placed for adoption by the Employee. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;
  - notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements of ERISA (section 609(a));

- a disabled or handicapped child who was covered under the Plan prior to attainment of the maximum age limit. See the "Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children" provision in the Extensions of Coverage section for further information.

See the Extensions of Coverage section for instances when these eligibility requirements may be waived or modified. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.
WHEN YOU CAN ENROLL AND EFFECTIVE DATE OF COVERAGE

The following chart outlines when you and your dependents can enroll for benefits, as well as your effective date of coverage (i.e., when your coverage begins). Keep in mind:

- A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee.
- In no instance will a Dependent's coverage become effective prior to the Employee's/Retiree's coverage effective date.
- For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.
- If an Employee and spouse are both eligible for coverage, both may be covered as Employees and as Dependents of each other; eligible children may be covered as Dependents of both spouses.
- An Employee may cover his spouse without covering eligible child(ren) or vice versa.

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<th>Effective Date of Coverage</th>
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<tbody>
<tr>
<td>As a new hire or retiree</td>
<td>If you become eligible on the 1st day of the month: Coverage is effective on that day if you complete and return the enrollment form within 31 days of your hire date.</td>
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<td>If you become eligible on any date after the 1st of the month: Coverage is effective on the first day of the calendar month after you become eligible if you complete and return the enrollment form within 31 days of your hire date.</td>
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<tr>
<td></td>
<td>If you do not enroll within 31 days: Your next opportunity to enroll will be during the annual enrollment period unless you experience a qualified life event, as described under Changing Coverage During the Year.</td>
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<tr>
<td>During the year, if you have a qualifying event, or event that provides you with special enrollment rights</td>
<td>Except for birth or adoption, coverage begins on the first day of the calendar month after the date on which the Plan received the completed change form if you complete and return the enrollment form within 31 days of the event.</td>
</tr>
<tr>
<td>See Changing Coverage During the Year for more information</td>
<td>For birth or adoption of a child: Coverage will begin on the date of birth or adoption (or placement for adoption if you complete and return the enrollment form within 60 days of the birth or adoption.</td>
</tr>
<tr>
<td></td>
<td>If you do not change your coverage within 31 days (60 days for the birth or adoption of a child): Your next opportunity to make a change will be during the annual enrollment period.</td>
</tr>
<tr>
<td>During annual enrollment</td>
<td>October 1 if you enroll during the annual enrollment period.</td>
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<td>If you do not enroll during this time: Your next opportunity to enroll will be during the next annual enrollment period unless you experience a qualified life event, as described under Changing Coverage During the Year.</td>
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Specific information about each enrollment opportunity is provided below and on the following page.
Enrollment Materials

- As a new hire and during annual enrollment: You will automatically receive enrollment materials, including an enrollment form that lists all of the options for which you can enroll.

- During the Year, when you experience a qualifying event: You must contact your Human Resources representative to receive a status change form.

Changing Coverage During the Year

There are two sets of regulations, established by the Federal government, that control the types of coverage changes you can make during a plan year. The regulations, as outlined on the following page, classify the changes as follows:

1. Change in Status Events: As provided by the Internal Revenue Code
   As a result of allowing you to pay for benefits on a before-tax basis, the government has established rules that control when you can change or enroll for coverage. Based on your situation, you may be able to:
   - change your coverage during the plan year (i.e., add or remove dependents to your existing coverage), or
   - late enroll, which refers to enrolling yourself and/or your dependents for coverage during the plan year, even though you declined coverage when you were first eligible or during a previous open enrollment period. Note: You must enroll for coverage in order to enroll your dependents.

2. Special Enrollment Rights: As provided by the Health Insurance Portability and Accountability Act – HIPAA. Under certain circumstances, even if you or your eligible dependents are not currently enrolled in a plan, the government requires that you and your eligible dependents be allowed to late enroll – enroll during the plan year even though you declined coverage when you were first eligible or during a previous open enrollment period. Note: You must enroll for coverage in order to enroll your dependents.

Important: Please review the following page carefully to find out:

- when enrollment will be allowed during the year, and
- the timeframe in which to complete and return the enrollment form(s).
## During the Year

<table>
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<th>Change in Status Events: As provided by the Internal Revenue Code</th>
<th>Enrollment Requirements: You must change (enroll/drop) coverage within</th>
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<td>• Change in your legal marital, including marriage, death of your spouse, divorce, legal separation or annulment.</td>
<td>31 days of the event</td>
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<tr>
<td>• Change in the number of your dependents, including death of your dependent.</td>
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<tr>
<td>• Change in your employment status, including termination or commencement of employment of you, your spouse or your dependent.</td>
<td></td>
</tr>
<tr>
<td>• Change in work schedule for you or your spouse, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.</td>
<td></td>
</tr>
<tr>
<td>• Your dependent satisfies or no longer meets the eligibility requirements for dependent, as described under Who is Eligible.</td>
<td></td>
</tr>
<tr>
<td>• A change in the place of residence or worksite of you or your spouse (Note: This move must affect your coverage options).</td>
<td></td>
</tr>
<tr>
<td>• You, your spouse or your dependents lose COBRA coverage.</td>
<td></td>
</tr>
<tr>
<td>• You, your spouse or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.</td>
<td></td>
</tr>
<tr>
<td>• If the plan receives a decree, judgment or court order, including a QMCSO pertaining to your dependent, you may add the child to the plan (if the decree, judgment or court order requires coverage) or drop the child from the plan (if the spouse is required to provide coverage).</td>
<td></td>
</tr>
<tr>
<td>• A significant change in benefit or cost of coverage for you or your spouse.</td>
<td></td>
</tr>
<tr>
<td>• Your spouse employer provides the opportunity to enroll or change benefits during an open enrollment period.</td>
<td></td>
</tr>
<tr>
<td>• Change in the number of your dependent children, including birth, adoption or placement for adoption.</td>
<td>60 days of the event</td>
</tr>
</tbody>
</table>

### Special Enrollment Rights: As provided by HIPAA

<table>
<thead>
<tr>
<th>Enrollment Requirements: You must change (enroll/drop) coverage within</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan*</td>
</tr>
<tr>
<td>• Occurrence of certain events such as marriage**</td>
</tr>
<tr>
<td>• Occurrence of certain events such as birth, adoption or placement for adoption**</td>
</tr>
<tr>
<td>• Eligibility for state premium subsidies under the Children’s Health Insurance Program or State Children’s Health Insurance Program (also known as Healthy Families in California); see next page for details</td>
</tr>
<tr>
<td>• Loss of coverage under Medicaid, the Children’s Health Insurance Program or State Children’s Health Insurance Program (also known as Healthy Families in California)</td>
</tr>
</tbody>
</table>

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* Loss of coverage means: COBRA coverage has been exhausted for reasons other than non-payment of premiums or fraud, loss due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.

** There is no requirement that protected individuals in this category must have had other coverage prior to the existence of their special enrollment rights.
Open Enrollment
You can make new decisions about your and your dependent's insurance, once a year during the open enrollment period (usually in September). Your new elections will become effective on October 1 and will remain in effect until the following September 30, unless you experience an event that would allow you to change your coverage during the year.

Reinstatement / Rehire
Employee benefits may be reinstated as if there had been no lapse in coverage (for himself and any Dependents who were covered at the point contributions ceased) if he/she returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA). Benefits may be reinstated even if the Employee discontinued paying his share of the cost of coverage causing coverage to terminate. Note: In this situation, the Plan Sponsor may require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Note: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.
TERMINATION OF COVERAGE

For information about continuing health benefits (including medical/prescription drugs, dental and vision coverage), after termination, see Extension of Coverage and/or COBRA Continuation Coverage.

Note: An Employee or Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his or her health status or need for health services.

Employee or Retiree
An Employee's or Retiree's coverage under the Plan will terminate at midnight on the last day of the month following the earliest of:

- termination of the Plan or Plan benefits as described herein;
- termination of participation in the Plan by the Employee or Retiree;
- the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);
- for an Employee, in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in Eligibility and Effective Dates section - except when coverage is extended under the Extensions of Coverage section;
- for a Retiree, which he/she turns age 65, unless he does not qualify for Medicare under the California Elder Bill or is not Medicare eligible;
- as to any one coverage or class, the date the Plan is amended or changed to exclude that coverage or class;
- the date the Employee/Retiree dies.

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

Dependent
A Dependent's coverage under the Plan will terminate at midnight on the end of the month following the earliest of:

- termination of the Plan or discontinuance of Dependent coverage under the Plan;
- termination of the coverage of the Employee or Retiree;
- a in which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the Extensions of Coverage section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCFO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.
EXTENSIONS OF COVERAGE

Coverage may be continued beyond the Termination of Coverage date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a dependent will not extend beyond the date the employee's coverage ceases. For information about continuing coverage, see COBRA Continuation Coverage.

Developmentally Disabled or Handicapped Dependent Children
A Dependent will not terminate solely by reason of his having attained the limiting age, and he/she will continue to be considered a covered Dependent under the Plan, as long as:

- he/she remains in such condition, and otherwise conforms to the definition of "Dependent,"
- on the day immediately prior to the attainment of such age, the child was a covered Dependent under the Plan,
- at the time of attainment of such age, the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness,
- the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition, and
- such child is primarily dependent upon the Employee for support and maintenance;

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may be required.

During Absence From Work
If an Employee fails to continue in eligible active status but is not terminated from employment (i.e., he is absent due to Accidental Injury, Sickness or a Qualified Leave of Absence), he/she will be permitted to continue health care coverages for himself and his Dependents, subject to payment of contributions. Any such extended coverage allowances will be provided on a non-discriminatory basis.

If an Employee fails to continue in eligible active status due to other leave of absence or temporary layoff, the Employer may elect to continue coverage, subject to payment of contributions. Such coverage may be continued to the end of the second Plan month following the Plan month in which the leave or layoff began. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted above, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates, the:

- end of the period for which the last contribution was paid, if such contribution is required;
- date of termination of this Plan.

Family and Medical Leave
To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year. In accordance with the FMLA, an Employee is entitled to continued coverage if he/she:

- has worked for the Employer for at least twelve months,
- has worked at least 1,250 hours in the year preceding the start of the leave, and
- is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child,
- the placement of a child with the Employee for adoption or foster care,
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition, or
- Employee's own serious health condition that makes him unable to perform the functions of his or her job.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.
During U.S. Military Service
Regardless of an Employer’s established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee’s eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements
To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee’s ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee’s departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee’s notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled “Maximum Period of Coverage” below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage
The Employee must pay the cost of coverage (herein “premium”). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee’s coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage
The maximum period of USERRA continuation coverage is the lesser of:

- 18 months, or
- the duration of Employee’s active military service.

Reinstatement of Coverage Following Active Duty
Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions. The Employee must return to employment:

- on the first full business day following completion of military service for military leave of 30 days or less,
- within 14 days of completion of military service for military leave of 31-180 days, or
- within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if it would have been satisfied had the coverage not been terminated due to the order to active military service.
Retirees & Surviving Spouses

Retirees
An Employee who retires from active service from a participating entity may elect to have continued coverage under the Plan’s Comprehensive Option or Basic Option. Extended coverage may also include the retiring Employee’s spouse and children who meet the Dependent eligibility criteria.

An eligible retired Employee (or the spouse of such a retiree) includes a person age 65 or older who is enrolled in or eligible for Medicare coverage. Plan benefits will be determined as though the retiree (or the retiree’s spouse) were enrolled for all Medicare coverages for which the person is eligible.

Election for continued coverage must be made within thirty-one (31) days of Employee’s loss of coverage as an active Employee. Except as required by law, if a retiree does not make a timely election he may be denied further opportunity to do so.

Surviving Spouses
The surviving spouse of a former Employee may elect coverage or continued coverage hereunder, if the former employee either:

- retired from employment with the District, or
- was, at the time of death, employed with the District.

Cost of Coverage
A retiree or surviving spouse will be required to contribute to the Plan at rates determined by the Plan Sponsor. Such rates may be subject to change.

Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants.

During Total Disability
If an Employee or Dependent is Totally Disabled on the date he becomes ineligible for coverage or continuation under COBRA, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

- upon termination of the Total Disability,
- twelve (12) months following the date coverage terminated,
- upon the individual’s eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition, or
- upon termination of the Plan.

Definition of Total Disability
"Total Disability" or "Totally Disabled" means:

- For an Employee, a disability resulting solely from a sickness, injury or pregnancy that prevents the Employee from performing the material and substantial duties of his regular occupation.

- For a Dependent, it is disability that prevents Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.
SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR LATE ENROLLEES

For Plan purposes, a "preexisting condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months before an individual's enrollment date. A Pregnancy will not be considered a preexisting condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a preexisting condition in the absence of a diagnosis of a condition related to the genetic information.

For purposes of the Plan and the above paragraph, the following will apply:

- Medical advice, diagnosis, care or treatment must have been received from a health care provider or practitioner duly licensed to provide such care under state law and who is operating within the scope of practice authorized by applicable state law.

- An individual's "enrollment date" is his first day of Plan coverage or, if there is a waiting period for coverage, the first day of such waiting period. For a special enrollee (i.e., an individual who becomes covered under the "Special Enrollment Rights"—see the Eligibility and Effective Dates section) or a late enrollee, the "enrollment date" is the individual's first day of Plan coverage.

This limitation does not apply to:

- employees or dependents (through age 18),
- individuals who are added to the Plan who have submitted a valid HIPAA Certificate, which indicates that there has been less than a 63-day interruption of coverage, in which case the preexisting condition exclusion period will be reduced by the period of creditable coverage as described below,
- prescription drug benefits, or
- the covered pregnancy of an employee or spouse.

The period of any pre-existing condition exclusion that would apply will be reduced by the number of days of creditable coverage. Creditable coverage includes coverage under a health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid or Medicare that occurred without a break in coverage of 63 days or more. Any coverage occurring prior to a break in coverage of 63 days or more is not credited against the pre-existing condition exclusion period.

HIPAA Coverage Certifications

Recent changes in federal law may affect you and/or your dependent's health coverage if you and/or your dependents are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll.

Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month or (18-month) exclusion period must be reduced by prior health coverage as long as there was no break in coverage equal to or exceeding 63 days. In other words, you will be given credit, based on the length of your prior coverage, toward satisfaction of a plan's pre-existing condition exclusion.

You and your dependents may be requested to present a certificate of coverage from any prior group health plan. So that you can prove to a new employer that you had prior health coverage, you will receive a certificate when coverage is lost under the Plan identifying your (and your dependents') prior health coverage. You have the right to obtain documented coverage going back as far as July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Beginning June 1, 1997, you and/or your covered dependents will receive a coverage certificate promptly after coverage is lost under the Plan. If you elect COBRA continuation coverage, you and your covered dependents will also receive a coverage certificate after COBRA coverage ends. Keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage when you join a new plan. You and/or your dependents, or someone on your behalf, may also request a coverage certificate within 24 months of when coverage was lost. To make the request, please contact the Human Resources Department.
Allowance for Prior “Creditable Coverage”

An individual (employee or dependent) who transfers to this Plan from another plan of “creditable coverage” within 63 days (i.e. not more than 62 days without coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate “creditable coverage” and to request a certificate of creditable coverage from the prior health plan(s). This Plan is available to help any such individual in obtaining such certificate(s).

An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the prior health plan(s). If the prior coverage is determined to be “creditable coverage,” the Plan enrollee will be credited with time covered under such prior plan(s) toward the time limits of this Plan’s pre-existing condition limitation or other time-covered requirements that may apply to Plan coverage.

“Creditable coverage” includes:

- coverage identified in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),
- group health plan (including a governmental or church plan),
- individual health insurance coverage,
- Medicare (other than solely under sec. 1928, Program for Distribution of Pediatric Vaccines),
- Medicaid,
- military-sponsored health care,
- a program of Indian Health Services,
- a state health benefits risk pool,
- the Federal Employees Health Benefits Program,
- a public health plan as defined in regulations and any health benefit plan of the Peace Corps Act.
Description of Benefits
MEDICAL OPTIONS

Having the appropriate medical coverage is essential to your and your family’s health and well being. The medical options available offer broad, comprehensive protection to cover a wide range of medical providers, services and supplies.

Keep in mind that if you or your dependents are enrolled in the medical plan:

- You and any covered dependents may automatically receive prescription benefit coverage, as described in this Summary Plan Description.

- The plan has a Case Management Program and Preauthorization Program to ensure that you are receiving the appropriate medical care in the most effective setting possible and that the services are covered. See Medical Plan Review Program for more information.

- Access to a Global Medical Benefit for surgical procedures. This program offers you a high quality network of hospital and physicians from around the world. All health care, as well as travel and hotel accommodations (for you and a companion of your choice) are covered at 100% with no cost sharing.

Important: The Plan Sponsor has the final authority, in its sole discretion, to determine whether any benefit is covered under the plans, and its determinations are conclusive and binding on all participants and dependents. See the General Information section for more information about filing claims and administration of the plan.

Utilization Management Program

Unnecessary medical care and hospital stays, or stays that last longer than necessary, cause medical costs to increase. Sometimes, individuals are hospitalized for procedures that can be performed safely, effectively and more comfortably in an alternative setting, such as a hospital’s outpatient department or physician’s office. As a result, the Plan Sponsor has contracted with an independent organization to provide:

- REQUIRED: Preauthorization to certify medical necessity when you or your dependent requires certain care or services (as listed on the following page), and if you need to continue a stay beyond the period initially certified.

- VOLUNTARY: Case Management will monitor your case until the treatment is completed. When extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient’s and Plan Sponsor’s consent, will provide case management services, including:
  - contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary,
  - evaluate and summarize the patient’s continuing medical needs,
  - assess the quality of current treatments,
  - coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor,
  - review the progress of alternative treatment after implementation, and
  - make appropriate recommendations to the Plan Sponsor.

Note: Additional information is provided on the following pages.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services. The name and phone number of the organization is shown on the Employee's coverage identification card, as well as under Important Numbers and Web Site Addresses.

Important: If you have any questions as to whether a particular medical procedure is covered under current standards, you should always check before incurring the expense, even if the mandatory review program does not apply.

Important:
Preauthorization is not a guarantee of coverage; the Utilization Management Program is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the Utilization Management Program will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.
Responsibility for Compliance
It is the Employee’s or Covered Person’s responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Required: Preauthorization
You are responsible for preauthorization or to in the following situations.

<table>
<thead>
<tr>
<th>Care or Services</th>
<th>Timeframe</th>
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</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Stays</strong></td>
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<tr>
<td>Including inpatient care for mental health or chemical</td>
<td>Prior to the admission</td>
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<tr>
<td>dependency treatment:</td>
<td>Within 48 hours of the admission.</td>
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<tr>
<td>• Scheduled or Non-emergency Admissions</td>
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<tr>
<td>• Non-scheduled, Emergency Admission</td>
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<tr>
<td>Important: These timeframes do not apply to a hospital</td>
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<tr>
<td>stay following childbirth; for additional information</td>
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<tr>
<td>about this type of coverage, see the definition of</td>
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<tr>
<td>Pregnancy under the section entitled Eligible Medical</td>
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<tr>
<td>Expenses</td>
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<tr>
<td><strong>To Continue a Stay Beyond the Period Certified</strong></td>
<td>Before the original timeframe</td>
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<tr>
<td><strong>Other Services and Supplies</strong></td>
<td>expires</td>
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<tr>
<td>• Home Health Care (including IV Therapy)</td>
<td>Prior to receiving services or</td>
</tr>
<tr>
<td>• Potentially Cosmetic / Investigative Services</td>
<td>supplies</td>
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<tr>
<td>• Transplant Evaluation</td>
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Note: If necessary, the Utilization Management Organization also provides retrospective review to determine the medical need for hospitalization or treatment after such services have taken place.

Failure to Receive Required Pre-Authorization
If you do not receive or use the required pre-authorization:

• Benefits otherwise payable will be reduced by 20%; this additional cost will apply to all professional and facility expenses incurred relative to the admission or listed procedure.

• Expenses for treatment or hospital stays that are not considered medically necessary will not be covered.

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

See “Pre-Service Claims” in the Claims Procedures section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program. Note: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).
Voluntary: Case Management Program

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient’s and Plan Sponsor’s consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers, care consultants and the hospital staff as necessary.

Case Management will:

- evaluate and summarize the patient’s continuing medical needs,
- assess the quality of current treatments,
- coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor,
- review the progress of alternative treatment after implementation, and
- make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

Important: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Delta TeamCare Disease Management Program

Delta’s Disease Management program can help a Plan participant manage a specific chronic condition through a free, voluntary and confidential program. The program provides a specially trained Disease Management Nurse, via telephone, to assist an enrollee in gaining greater confidence in management of their condition. Disease Management targets:

- asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, hypertension, congestive heart failure, high cholesterol, stroke and chronic low back pain, and
- persons with a chronic condition (as identified through an analysis of health care claims, self-referral or a Physician’s recommendation) will be invited to participate in the program.

A Disease Management Nurse will be assigned to assess the current situation, answer questions, educate the patient about self-care techniques and assist with lifestyle changes for maximum health and quality of life. Ongoing telephone counseling and educational materials will increase the patient’s understanding of his condition and help him become better at using self-care and improve his overall health. Disease Management supplements, but does not replace, a person’s Physician’s care and advice.
Global Medical Benefit
If you find out from your doctor that you need surgery, you have the option to select a Satori Work Medical network provider. The program offers the following services/care:

- **High-Quality Network of Hospitals and Physicians**: You now have access to International Centers of Excellence where high quality surgical procedures are performed in hospitals designed to cater to U.S. patients. All physicians are U.S/U.K. or equivalency trained and Board Certified, and all are fluent in English.

- **Quality Assurance**: The global network is comprised of hospitals that are Joint Commission International accredited, the same accreditation process utilized by hospitals in the United States. In addition, all hospitals participate in an ongoing assessment by our Chief Medical Officer to ensure high quality patient care and customer service.

- **No Out-of-Pocket Costs or Bills**: Your benefit is covered at 100%. Covered participants pay no deductibles, copay or coinsurance. No bills will be sent for any of the care or services provided by Satori.

- **Medical and Travel Services**: A nurse Patient Advocate will answer all questions and guide the covered individual through every step, including:
  - coordinating your care,
  - transferring medical records,
  - setting up a conference call with your international physician,
  - scheduling your procedure,
  - making hotel and airfare reservations, and
  - scheduling your follow-up appointment with your U.S. physician upon your return

- **Companion Care**: Hotel accommodations and airfare will be provided, at no additional cost, for the covered individual and a companion of his/her choice.

*How it Works*
Once you find out that one of the surgeries listed below has been recommended, the only thing you need to do is contact a Satori Nurse Patient Advocate. See Important Numbers and Website Address for contact information.

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Ancillary Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following is a list of covered procedures (subject to change)</td>
<td>The following is a list of covered services (subject to change)</td>
</tr>
<tr>
<td><strong>Cardiac</strong>:</td>
<td><strong>Hospital, professional and ancillary services</strong>,</td>
</tr>
<tr>
<td>o coronary artery bypass grafts (CABG),</td>
<td><strong>Airfare for both patient and companion,</strong></td>
</tr>
<tr>
<td>o valve replacement,</td>
<td><strong>Hotel accommodations at Intercontinental for patient and companion,</strong></td>
</tr>
<tr>
<td>o pacemaker (single and double chamber), and</td>
<td><strong>Personal accident policy for patient related to medical travel and procedure,</strong></td>
</tr>
<tr>
<td>o Implantable Cardioverter-Defibrillator (ICD).</td>
<td><strong>Daily ground transportation,</strong></td>
</tr>
<tr>
<td><strong>Orthopedic</strong>:</td>
<td><strong>24/7 Satori Customer Service,</strong></td>
</tr>
<tr>
<td>o total or partial knee arthroplasty,</td>
<td><strong>Satori in-house travel services, and</strong></td>
</tr>
<tr>
<td>o hip resurfacing,</td>
<td><strong>Satori Nurse Patient Advocate services (liaison between U.S. and international physicians).</strong></td>
</tr>
<tr>
<td>o total hip arthroplasty, and</td>
<td>o Sunita Gopal, M.D.</td>
</tr>
<tr>
<td>o shoulder joint replacement.</td>
<td>o 24/7 Satori Nurse Patient Advocate Services</td>
</tr>
<tr>
<td><strong>Spine</strong>:</td>
<td></td>
</tr>
<tr>
<td>o cervical discectomy, and</td>
<td></td>
</tr>
<tr>
<td>o lumbar laminectomy (with and without fusion).</td>
<td></td>
</tr>
<tr>
<td><strong>Bariatric</strong>:</td>
<td></td>
</tr>
<tr>
<td>o lap band,</td>
<td></td>
</tr>
<tr>
<td>o gastric bypass, and</td>
<td></td>
</tr>
<tr>
<td>o gastric sleeve</td>
<td></td>
</tr>
<tr>
<td><strong>Men and women's health</strong>:</td>
<td></td>
</tr>
<tr>
<td>o hysterectomy, and</td>
<td></td>
</tr>
<tr>
<td>o prostatectomy.</td>
<td></td>
</tr>
</tbody>
</table>

*Participating Providers*
Though the actual Participating Providers is subject to change, Satori World Medical Group currently has Centers of Excellence in Costa Rica, India, Mexico, Philippines, Singapore, Thailand and Turkey.
Within the United States
A Preferred Provider Organization (PPO) option allows you to receive medical care and services from any physician or facility you choose. As a PPO participant, you do not need to select a primary care physician, nor do you need referrals for a specialist. There are two types of providers:

- **In-network Providers:** Including physicians and hospitals, which have agreed to become part of the organization and provide care to members at a lower negotiated rate. If you use in-network providers, benefit coverage will be greater and your out-of-pocket expenses will be lower.

- **Out-of-network Providers:** Any provider not affiliated with the network is out-of-network. If you obtain care from an out-of-network provider, your benefit coverage will be lower and your out-of-pocket expenses will be higher because you are responsible for all expenses that exceed the Usual, Reasonable and Customary allowance (the range of fees usually charged by health care providers for the same service or supply in the same (or comparable) geographic area).

**Finding a Provider:** Because physicians and hospitals frequently change their affiliations with in-networks and organizations, printed directories become quickly outdated. To ensure that the provider you are going to receive treatment from is currently in-network, contact the medical plan’s claims administrator before each visit or hospital stay. For contact information, see Important Numbers and Web Site Addresses.

Although there may be circumstances when an in-network provider cannot be used, out-of-network provider services will be covered at the Out-of-network benefit levels. In this situation, the in-network benefit levels will be applied to out-of-network Usual, Customary and Reasonable charges:

- **Ancillary Services:** Services of an out-of-network emergency room Physician, urgent care Physician, radiologist or pathologist will be covered at the Network benefit levels if such services are received while a Covered Person is being treated in the emergency room of a Network Hospital or a Network Urgent Care Facility. Services of an out-of-network radiologist, pathologist or anesthesiologist will be covered at the Network benefit levels if such services are received while a Covered Person is confined or is having Outpatient surgery performed at a Network facility.

- **Emergency Care:** If a Covered Person uses an out-of-network provider or the emergency room of an out-of-network Hospital because it was not reasonably possible to get to a Network provider or Network Hospital, the Network benefit levels will apply, subject to review by the Utilization Management Organization. If a Covered Person is admitted to an out-of-network Hospital following an emergency room visit, all Inpatient Physician and other Inpatient services and supplies will be paid at Network benefit levels, subject to approval by the Utilization Management Organization (see Utilization Management Program) and until the patient’s condition is stabilized. Upon stabilization, if the patient does not transfer to Network provider care, Out-of-network care will be covered at the Out-of-network benefit levels.

- **Unavailable Services:** If there are no Network Hospitals or professionals within a 50-mile radius of a Covered Person’s residence, or if a Covered Person requires services that are only available from an out-of-network provider, then such Out-of-network care will be covered at the Network benefit levels.

The Plan also offers supplemental networks in addition to the primary “Network” as is referenced above. A Covered Person should contact Member Services at the number on the Employee’s ID card for the names of supplemental networks. Expenses of supplemental network providers may qualify for the in-network benefit levels of the Plan, but their negotiated rates may reduce a Covered Person’s out-of-pocket expenses.
In Mexico (Comprehensive Plus Frontera Only)
Except in limited situations, if a Covered Person wishes to obtain medical care in Mexico, ALL HEALTH CARE must be provided, authorized or ordered by Frontera Network providers. The Plan Sponsor will automatically provide a Plan participant, without charge, with information about how he can access directories of Frontera Network Providers. The directories will be available either in hard copy as a separate document, or in electronic format.

Although there may be circumstances when an in-network provider cannot be used, out-of-network provider services will be covered at the out-of-network benefit levels. In this situation, the in-network benefit levels will be applied to out-of-network Usual, Customary and Reasonable charges:

- **Ancillary Service:** Services of an out-of-network radiologist, pathologist, anesthesiologist or emergency room physician will be covered at the Network benefit levels if such services are received while a Covered Person is receiving covered treatment at a Network facility.

- **In a Medical Emergency:** A Covered Person should try to access a Network provider for treatment. However, if immediate treatment is required and this is not possible, the services of out-of-network providers will be covered until the patient’s condition has stabilized to the extent that he can be safely transferred to Network provider care. At that point, if transfer does not take place, benefits will cease.

**Vision Benefits**
Preventive vision exams are provided in Mexico at $5/exam.
### Summary of Deductibles, Out-of-Pocket and Lifetime Maximums

The chart below shows what portion of expenses you will be responsible for, as well as how maximums are determined.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Basic (US Only)</th>
<th>Comprehensive (US Only)</th>
<th>Comprehensive + Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered expenses applied to your in-network deductible do not count toward your out-of-network deductible and vice versa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>$750</td>
<td>$1,000</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$2,250</td>
<td>$3,000</td>
<td>$900</td>
</tr>
</tbody>
</table>

*Common Accident Provision:* If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. The Individual Deductible requirement for each member of the family who is involved in the accident will be credited with a pro-rata share of the 1 Individual Deductible amount applied to accident-related expenses.

<table>
<thead>
<tr>
<th><strong>Calendar Year Out-of-Pocket Maximum</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Once an individual or family has paid the out-of-pocket maximum, all Eligible Expenses will be paid at 100% for the balance of the Calendar Year. Covered expenses applied to your in-network out-of-pocket maximum do not count toward your out-of-network out-of-pocket maximum and vice versa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>$5,000</td>
<td>$10,000</td>
<td>$1,000</td>
<td>$5,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$15,000</td>
<td>$30,000</td>
<td>$3,000</td>
<td>$15,000</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

The out-of-pocket maximums do not apply to:
- amounts applied or paid to satisfy any Copay requirements,
- expenses in excess of the usual, reasonable and customary levels are not applicable to the out-of-pocket maximum, and
- expenses which become the Covered Person’s responsibility for failure to comply with the Pre-Authorization Program.

| **Lifetime Maximum** | Unlimited       |                         |                          |                          |           |
Medical Schedule of Benefits

In most cases, benefits are subject to either a copay at the time care is received or a coinsurance amount that will be billed to you or your dependents after care is received.

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.

- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

- **In-Network Providers:** Physicians or facilities that allow you to receive medical care and services at lower, negotiated rates. Your out-of-pocket expenses will be lower if you use contract providers.

**Out-of-Network Provider:** Any other providers that are not under a contract to provide lower negotiated rates. Benefits for out-of-network providers will be paid based on the Usual, Customary and Reasonable (UCR) rate.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Basic (US Only)</th>
<th>Comprehensive (US Only)</th>
<th>Comprehensive + Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Benefits for air ambulance are limited to $19,000 per incident.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic and Acupuncture</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chiropractic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Office Visits, per visit</td>
<td>$30†</td>
<td>50%</td>
<td>$30†</td>
</tr>
<tr>
<td>- In-Office Lab &amp; X-ray Services</td>
<td>$30†</td>
<td>50%</td>
<td>$30†</td>
</tr>
<tr>
<td>- Acupuncture, per visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Combined Calendar Year Maximum</td>
<td>$1,500; this limit does not apply to related diagnostic services.</td>
<td></td>
<td>$1,500; this limit does not apply to related diagnostic services.</td>
</tr>
<tr>
<td><strong>Colonoscopy (Preventive or Diagnostic)</strong></td>
<td>100%†</td>
<td>50%</td>
<td>100%†</td>
</tr>
<tr>
<td>Facility and Surgical Fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Lab &amp; X-Ray</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pre-Admission Testing</td>
<td>80%†</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>- Other Outpatient Diagnostic Services</td>
<td>80%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hearing Exams &amp; Hearing Aids</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hearing Exams, per visit</td>
<td>$30†</td>
<td>50%</td>
<td>$30†</td>
</tr>
<tr>
<td>- Hearing Aids (limited to $600 per ear, per 60-month period)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Limited to $10,000 per Lifetime and to care provided within 6 months of the date it begins. Inpatient respite care is limited to 8 days per Lifetime. Benefits for pre-death and bereavement counseling for the patient’s family are limited to $200. Bereavement counseling is limited to services provided within 12 months after the Covered Person dies.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Calendar Year Deductible does not apply.
Medical Schedule of Benefits, continued

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.

- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Basic (US Only)</th>
<th>Comprehensive (US Only)</th>
<th>Comprehensive + Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Care, per admission</td>
<td>80%</td>
<td>$500, then 50%</td>
<td>80%</td>
</tr>
<tr>
<td>• Emergency Room Use:</td>
<td>$75†</td>
<td>50%</td>
<td>$75†</td>
</tr>
<tr>
<td>- Medical Emergency</td>
<td>80%</td>
<td>50%</td>
<td>$75†</td>
</tr>
<tr>
<td>- Non-emergency</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>• Other Outpatient Services &amp; Supplies</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Medical Equipment &amp; Supplies</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>• Maximum</td>
<td>$10,000/lifetime</td>
<td>$10,000/lifetime</td>
<td>$10,000/lifetime</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td>$15†</td>
<td>50%</td>
<td>$15†</td>
</tr>
<tr>
<td>• Outpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient (See Hospital Services above)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Services, Private Duty</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>• Limit per Day</td>
<td>$125</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Visits</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>• Office or Home Visits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- primary care Physician, per visit</td>
<td>$15†</td>
<td>50%</td>
<td>$15†</td>
</tr>
<tr>
<td>- specialist, per visit</td>
<td>$30†</td>
<td>50%</td>
<td>$30†</td>
</tr>
<tr>
<td>• All Other Services</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office Visits, per visit</td>
<td>$30†</td>
<td>50%</td>
<td>$30†</td>
</tr>
<tr>
<td>• All Other Services</td>
<td>80%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>An &quot;office visit&quot; includes all covered services performed at the time of the visit. Benefits for podiatrist services are limited to $2,000/Calendar Year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs, Outpatient</strong></td>
<td>$5†</td>
<td></td>
<td>$5†</td>
</tr>
<tr>
<td>• Formulary</td>
<td>$20†</td>
<td></td>
<td>$20†</td>
</tr>
<tr>
<td>- Generic</td>
<td>$35†</td>
<td></td>
<td>$35†</td>
</tr>
<tr>
<td>• Non-Formulary</td>
<td>$5†</td>
<td></td>
<td>$5†</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>$15†</td>
<td>50%</td>
<td>$15†</td>
</tr>
<tr>
<td>• In-Office Services, per visit</td>
<td>100%†</td>
<td>50%</td>
<td>100%†</td>
</tr>
<tr>
<td>• Mammogram</td>
<td>$500, then 50%</td>
<td></td>
<td>$500, then 50%</td>
</tr>
<tr>
<td>See Eligible Medical Expenses for details.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Calendar Year Deductible does not apply.
Medical Schedule of Benefits, continued

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.

- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
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<th>Comprehensive + Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>80%</td>
<td>$500, then 50%</td>
<td>80%</td>
</tr>
<tr>
<td>Per admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 50% of the Semi-Private Room Charge of the Hospital of prior confinement. Coverage is limited to 90 days per confinement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapy per visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational, physical or speech for the improvement of a condition; maintenance therapy is not covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$15†</td>
<td>50%</td>
<td>$15†</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Transplant-Related Expenses</strong></td>
<td>Based on the type of services provided</td>
<td>Based on the type of services provided</td>
<td>Based on the type of services provided</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical Emergency, per visit</td>
<td>$30†</td>
<td>50%</td>
<td>$30†</td>
</tr>
<tr>
<td>• Non-Emergency</td>
<td>$30†</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

† Calendar Year Deductible does not apply.
CATASTROPHIC MEDICAL OPTION

A Preferred Provider Organization (PPO) option allows you to receive medical care and services from any physician or facility you choose. As a PPO plan participant, you do not need to select a primary care physician, nor do you need referrals for a specialist. IMPORTANT: Prescription drug benefits are not covered under this plan.

There are two types of providers:

- **In-network Providers:** Including physicians and hospitals, which have agreed to become part of the organization and provide care to members at a lower negotiated rate. If you use in-network providers, benefit coverage will be greater and your out-of-pocket expenses will be lower.

- **Out-of-network Providers:** Any provider not affiliated with the network is out-of-network. If you obtain care from an out-of-network provider, your benefit coverage will be lower and your out-of-pocket expenses will be higher because you are responsible for all expenses that exceed the Usual, Reasonable and Customary allowances (the range of fees usually charged by health care providers for the same service or supply in the same (or comparable) geographic area).

**Finding a Provider:** Because physicians and hospitals frequently change their affiliations with in-networks and organizations, printed directories become quickly outdated. To ensure that the provider you are going to receive treatment from is currently in-network, contact the medical plan’s claims administrator before each visit or hospital stay. For contact information, see Important Numbers and Web Site Addresses.

Although there may be circumstances when an in-network provider cannot be used, out-of-network provider services will be covered at the Out-of-network benefit levels. In this situation, the in-network benefit levels will be applied to out-of-network Usual, Customary and Reasonable charges:

- **Ancillary Services:** Services of an out-of-network emergency room Physician, urgent care Physician, radiologist or pathologist will be covered at the Network benefit levels if such services are received while a Covered Person is being treated in the emergency room of a Network Hospital or a Network Urgent Care Facility. Services of an out-of-network radiologist, pathologist or anesthesiologist will be covered at the Network benefit levels if such services are received while a Covered Person is confined or is having Outpatient surgery performed at a Network facility.

- **Emergency Care:** If a Covered Person uses an out-of-network provider or the emergency room of an out-of-network Hospital because it was not reasonably possible to get to a Network provider or Network Hospital, the Network benefit levels will apply, subject to review by the Utilization Management Organization. If a Covered Person is admitted to an out-of-network Hospital following an emergency room visit, all Inpatient Physician and other Inpatient services and supplies will be paid at Network benefit levels, subject to approval by the Utilization Management Organization (see Utilization Management Program) and until the patient’s condition is stabilized. Upon stabilization, if the patient does not transfer to Network provider care, Out-of-network care will be covered at the Out-of-network benefit levels.

- **Unavailable Services:** If there are no Network Hospitals or professionals within a 50-mile radius of a Covered Person’s residence, or if a Covered Person requires services that are only available from an out-of-network provider, then such Out-of-network care will be covered at the Network benefit levels.

The Plan also offers supplemental networks in addition to the primary “Network” as is referenced above. A Covered Person should contact Member Services at the number on the Employee’s ID card for the names of supplemental networks. Expenses of supplemental network providers may qualify for the Network benefit levels of the Plan, but their negotiated rates may reduce a Covered Person’s out-of-pocket expenses.
## Summary of Deductibles, Out-of-Pocket and Lifetime Maximums

The chart below shows what portion of expenses you will be responsible for, as well as how maximums are determined.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Catastrophic Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>in-Network</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Covered expenses applied to your in-network deductible do not count toward your out-of-network deductible and vice versa</td>
<td></td>
</tr>
<tr>
<td>- <strong>Individual</strong>: The amount for which a Covered Person must contribute toward payment of eligible medical expenses before the Plan begins to pay for benefits (not all benefits are subject to the deductible).</td>
<td>$1,000</td>
</tr>
<tr>
<td>- <strong>Family</strong>: The amount for which a Family must contribute toward payment of eligible medical expenses before the Plan begins to pay for benefits (not all benefits are subject to the deductible). For Medical expenses incurred collectively by family members (a covered Employee and his/her covered dependents) during a Calendar Year.</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

*Common Accident Provision*: If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. The Individual Deductible requirement for each member of the family who is involved in the accident will be credited with a pro-rata share of the 1 Individual Deductible amount applied to accident-related expenses.

<table>
<thead>
<tr>
<th><strong>Calendar Year Out-of-Pocket Maximum</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Once an individual or family has paid the out-of-pocket maximum, all Eligible Expenses will be paid at 100% for the balance of the Calendar Year. Covered expenses applied to your in-network out-of-pocket maximum do not count toward your out-of-network out-of-pocket maximum and vice versa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <strong>Individual</strong></td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>- <strong>Family</strong></td>
<td>$15,000</td>
<td>$45,000</td>
</tr>
</tbody>
</table>

The out-of-pocket maximums do not apply to or include:
- amounts applied or paid to satisfy any Copay requirements,
- expenses in excess of the usual, reasonable and customary levels are not applicable to the out-of-pocket maximum, and
- expenses which become the Covered Person’s responsibility for failure to comply with the Pre-Authorization Program.

<table>
<thead>
<tr>
<th><strong>Lifetime Individual Maximum</strong></th>
<th>Unlimited</th>
</tr>
</thead>
</table>

Imperial County Schools Voluntary Employees Benefits Association / page 36
Medical Schedule of Benefits

In most cases, benefits are subject to either a copay at the time care is received or a coinsurance amount that will be billed to you or your dependents after care is received.

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.

- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

- **In-Network Providers:** Physicians or facilities that allow you to receive medical care and services at lower, negotiated rates. Your out-of-pocket expenses will be lower if you use contract providers.

- **Out-of-Network Provider:** Any other providers that are not under a contract to provide lower negotiated rates. Benefits for out-of-network providers will be paid based on the Usual, Customary and Reasonable (UCR) rate.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Ambulance</td>
<td>70%</td>
</tr>
<tr>
<td>Benefits for air ambulance are limited to $19,000 per incident</td>
<td></td>
</tr>
<tr>
<td>Chiropractic and Acupuncture</td>
<td>$30†</td>
</tr>
<tr>
<td>- Office Visits, per visit</td>
<td>100%†</td>
</tr>
<tr>
<td>- In-Office Lab &amp; X-ray Services</td>
<td>$30†</td>
</tr>
<tr>
<td>Acupuncturist, per visit</td>
<td></td>
</tr>
<tr>
<td>Combined Calendar Year Maximum</td>
<td>$1,500; this limit does not apply to related diagnostic services.</td>
</tr>
<tr>
<td>Colonoscopy (Preventive or Diagnostic)</td>
<td>100%†</td>
</tr>
<tr>
<td>Facility and Surgical Fees</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Lab &amp; X-Ray</td>
<td>70%†</td>
</tr>
<tr>
<td>- Pre-Admission Testing</td>
<td></td>
</tr>
<tr>
<td>- Other Outpatient Diagnostic Services</td>
<td>70%</td>
</tr>
<tr>
<td>Hearing Exams &amp; Hearing Aids</td>
<td></td>
</tr>
<tr>
<td>- Hearing Exams &amp; Tests, per visit</td>
<td>$30†</td>
</tr>
<tr>
<td>- Hearing Aids (limited to $600 per ear, per 60-month period)</td>
<td>50%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>70%</td>
</tr>
<tr>
<td>Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>70%</td>
</tr>
<tr>
<td>Limited to $10,000 per Lifetime and to care provided within 6 months of the date it begins. Inpatient respite care is limited to 8 days per Lifetime. Benefits for pre-death and bereavement counseling for the patient's family are limited to $200. Bereavement counseling is limited to services provided within 12 months after the Covered Person dies.</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>70%</td>
</tr>
<tr>
<td>- Inpatient Care, per admission</td>
<td></td>
</tr>
<tr>
<td>- Emergency Room Use:</td>
<td></td>
</tr>
<tr>
<td>- Medical Emergency</td>
<td>$75†</td>
</tr>
<tr>
<td>- Non-emergency</td>
<td>70%</td>
</tr>
<tr>
<td>- Other Outpatient Services &amp; Supplies</td>
<td>70%</td>
</tr>
</tbody>
</table>

† Calendar Year Deductible does not apply.
Medical Schedule of Benefits, continued

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.
- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Medical Equipment &amp; Supplies</strong></td>
<td>70%</td>
</tr>
<tr>
<td>• Maximum</td>
<td></td>
</tr>
<tr>
<td>* Note: This benefit maximum does not apply to prosthetic appliances.</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$15†</td>
</tr>
<tr>
<td>* Inpatient (See Hospital Services above)</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Services, Private Duty</strong></td>
<td>70%</td>
</tr>
<tr>
<td>• Limit per Day</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Visits</td>
<td>70%</td>
</tr>
<tr>
<td>• Office or Home Visits:</td>
<td></td>
</tr>
<tr>
<td>- primary care Physician, per visit</td>
<td>$15†</td>
</tr>
<tr>
<td>- specialist, per visit</td>
<td>$30†</td>
</tr>
<tr>
<td>• All Other Services</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Office Visits, per visit</td>
<td>$30†</td>
</tr>
<tr>
<td>• All Other Services</td>
<td>1000%†</td>
</tr>
<tr>
<td>An &quot;office visit&quot; includes all covered services performed at the time of the visit. Benefits for podiatrist services are limited to $2,000/Calendar Year.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs, Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>In-Office Services, per visit; see Eligible Medical Expenses for details.</td>
<td>$15†</td>
</tr>
<tr>
<td><strong>Rehabilitation Hospital</strong></td>
<td>70%</td>
</tr>
<tr>
<td>Per admission</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>70%</td>
</tr>
<tr>
<td>Per admission</td>
<td></td>
</tr>
<tr>
<td>Limited to 50% of the Semi-Private Room Charge of the Hospital of prior confinement. Coverage is limited to 90 days per confinement.</td>
<td></td>
</tr>
<tr>
<td><strong>Therapy, Outpatient per visit</strong></td>
<td>$15†</td>
</tr>
<tr>
<td>Occupational, physical or speech for the improvement of a condition; Maintenance therapy is not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>Transplant-Related Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>Based on the type of services provided</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
</tr>
<tr>
<td>• Medical Emergency, per visit</td>
<td>$30†</td>
</tr>
<tr>
<td>• Non-Emergency</td>
<td>70%</td>
</tr>
<tr>
<td>Note: $30 Copay is waived if the Covered Person is admitted to the Hospital directly from the Urgent Care Facility.</td>
<td></td>
</tr>
</tbody>
</table>

† Calendar Year Deductible does not apply.
IMPORTANT WARNING:
Except in the case of a medical emergency, this Option provides coverage ONLY when La Nueva Frontera providers are utilized. As a result, do to limited services available in Mexico, THERE MAY BE NO BENEFITS FOR THE FOLLOWING CARE OR SERVICES: mental health, substance abuse or transplants.

To receive benefits under this option, all benefit must be received through the “La Nueva Frontera” Network in Mexico. The Plan Sponsor will automatically provide a Plan participant, without charge, with information about how he can access directories of Network Providers. The directories will be available either in hard copy as a separate document, or in electronic format.

Medical Emergency
In a medical emergency, when a La Nueva Frontera provider cannot be used:

- A Covered Person should try to access a Network provider for treatment. However, if immediate treatment is required and this is not possible, the services of out-of-network providers will be covered until the patient’s condition has stabilized to the extent that he can be safely transferred to Network provider care (either in Mexico by a La Nueva Frontera provider or to a stateside, in-network Anthem Blue Cross provider). At that point, if transfer does not take place, benefits will cease.

- In-network benefit levels applied will be based on Usual, Customary and Reasonable (UCR) charges. UCR is the charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term “area” as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

Summary of Deductibles, Out-of-Pocket and Lifetime Maximums
The chart below shows what portion of expenses you will be responsible for, as well as how maximums are determined.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>La Nueva Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out-of-Network Coverage Only available in a Medical Emergency</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Lifetime Individual Maximum</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
Medical Schedule of Benefits
In most cases, benefits are subject to either a copay at the time care is received or a coinsurance amount that will be billed to you or your dependents after care is received.

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.
- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>La Nueva Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out-of-Network Coverage Only</td>
</tr>
<tr>
<td></td>
<td>available in a Medical Emergency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $19,000 in benefits will be available for air ambulance in a Medical Emergency.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthing Center</th>
<th>100%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chiropractic and Acupuncture</th>
<th>$5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to $5,000/ calendar year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Lab &amp; X-Ray</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Admission Testing and Other Outpatient Diagnostic Services</td>
<td></td>
</tr>
</tbody>
</table>

Benefits for outpatient x-rays are limited to a maximum of $1,500 per calendar year and benefits outpatient laboratory tests are limited to a maximum of $750 per calendar year. Tests that are part of a routine exam (see Preventive care) are not subject to this limit.

<table>
<thead>
<tr>
<th>Hearing Exams &amp; Hearing Aids</th>
<th>See Preventive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hearing Exams &amp; Tests, per visit</td>
<td></td>
</tr>
<tr>
<td>• Hearing Aids (limited to $600 per ear, per 60-month period)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Care</th>
<th>Not covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospice Care</th>
<th>Not covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Care, per admission</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Emergency</td>
</tr>
<tr>
<td>• Non-emergency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Outpatient Services &amp; Supplies</th>
<th>100%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medical Equipment &amp; Supplies</th>
<th>100% up to $5,000/lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: This benefit maximum does not apply to prosthetic appliances.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health &amp; Substance Abuse</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Limited benefits are available through the Employee Assistance Program (EAP); see this section for additional information.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing Services, Private Duty</th>
<th>100% up to $75/day</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Visits</td>
<td></td>
</tr>
<tr>
<td>• Office or Home Visits:</td>
<td></td>
</tr>
<tr>
<td>- primary care Physician, per visit</td>
<td></td>
</tr>
<tr>
<td>- specialist, per visit</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Surgery</td>
<td>100%</td>
</tr>
<tr>
<td>• All Other Services</td>
<td>100%</td>
</tr>
</tbody>
</table>
Schedule of Medical Benefits, continued

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.
- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>La Nueva Frontera</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out-of-Network Coverage Only</td>
</tr>
<tr>
<td></td>
<td>Covered in a Medical Emergency</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Based on the type of services provided</td>
</tr>
<tr>
<td>Benefits are limited to $2,000/Calendar Year.</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs, Outpatient</td>
<td></td>
</tr>
<tr>
<td>• Formulary</td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>$5</td>
</tr>
<tr>
<td>• Brand-Name Drug</td>
<td>$5</td>
</tr>
<tr>
<td>• Non-Formulary</td>
<td>$5</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
</tr>
<tr>
<td>• Well-Adult Physical</td>
<td>$5</td>
</tr>
<tr>
<td>• Well Woman Exam</td>
<td>$5</td>
</tr>
<tr>
<td>• Mammograms</td>
<td>100%</td>
</tr>
<tr>
<td>• Colonoscopy</td>
<td>100%</td>
</tr>
<tr>
<td>• Prostate (PSA) Test</td>
<td>100%</td>
</tr>
<tr>
<td>• Hearing Exam</td>
<td>$5</td>
</tr>
<tr>
<td>• Vision Exam</td>
<td>$5</td>
</tr>
<tr>
<td>• Well Child Care, per visit</td>
<td>$5</td>
</tr>
<tr>
<td>Rehabilitation Hospital</td>
<td>100%</td>
</tr>
<tr>
<td>Per admission</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100%</td>
</tr>
<tr>
<td>Per admission</td>
<td></td>
</tr>
<tr>
<td>Limited to 50% of the Semi-Private Room Charge of the Hospital of prior confinement. Coverage is limited to 90 days per confinement.</td>
<td></td>
</tr>
<tr>
<td>Therapy, per visit</td>
<td>$1,000/calendar year</td>
</tr>
<tr>
<td>Occupational, physical or speech for the improvement of a condition; maintenance therapy is not covered</td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>$5</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>$5</td>
</tr>
<tr>
<td>Transplant-Related Expenses</td>
<td>Not covered</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td></td>
</tr>
<tr>
<td>• Medical Emergency, per visit</td>
<td>$10</td>
</tr>
<tr>
<td>• Non-Emergency</td>
<td>$10</td>
</tr>
</tbody>
</table>
COORDINATION OF BENEFITS (COB) OPTION

Based on the limited benefits, in most situations, this coverage option is elected only if you have other health insurance coverage (i.e., your spouse’s coverage or an independent/private medical plan).

This Preferred Provider Organization (PPO) option allows you to receive medical care and services from any physician or facility you choose. As a PPO participant, you do not need to select a primary care physician, nor do you need referrals for a specialist. There are two types of providers:

- **In-Network Providers**: When you use Anthem Blue Cross physicians or facilities, you to receive medical care and services at lower, negotiated rates (i.e., your out-of-pocket expenses will be lower).

- **Out-of-Network Provider**: Any other providers that are not part of the Anthem Blue Cross Network. **IMPORTANT**: Benefits for out-of-network providers will be paid based on the Usual, Customary and Reasonable (UCR) rate. A charge is considered usual, customary and reasonable if it falls within the range of fees usually charged by health care providers for the same service or supply in the same (or comparable) geographic area; charges above UCR will not be paid. Your out-of-pocket expenses will be higher if you use out-of-network providers.

Finding a Provider: Because physicians and hospitals frequently change their affiliations with in-networks and organizations, printed directories become quickly outdated. To ensure that the provider you are going to receive treatment from is currently in-network, contact the medical plan’s claims administrator before each visit or hospital stay. For contact information, see Important Numbers and Web Site Addresses.

**Medical Schedule of Benefits**

In most cases, benefits are subject to either a copay at the time care is received or a coinsurance amount that will be billed to you or your dependents after care is received.

- **Copay (shown as a dollar amount)**: Refers to the amount you pay, at the time covered care or services are received.

- **Coinsurance (shown as a percentage)**: Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>In-Network</th>
<th>Out-of-Network (Based on UCR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Benefits for air ambulance limited to $19,000 per incident.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic and Acupuncture</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Limited to $1,500/ calendar year; this limit does not apply to related diagnostic services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Exams &amp; Hearing Aids</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Hearing Aids limited to $500 per ear, per 60-month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>- Inpatient Care, per admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Emergency Room Use:</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>- Medical Emergency</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>- Non-emergency</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>- Other Outpatient Services &amp; Supplies</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Medical Equipment &amp; Supplies</strong></td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Benefits are limited to a maximum of $10,000 per Lifetime. This benefit limit does not apply to prosthetic appliances.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Schedule of Medical Benefits, continued

- **Copay (shown as a dollar amount):** Refers to the amount you pay, at the time covered care or services are received.

- **Coinsurance (shown as a percentage):** Refers to the amount the plan pays after covered care or services are received and you submit a claim.

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>In-Network</th>
<th>Out-of-Network (Based on UCR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>• Inpatient (See Hospital Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Services, Private Duty</td>
<td>30% up to $125/day</td>
<td>30% up to $125/day</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits are limited to $2,000/Calendar Year.</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Prescription Drugs, Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Formulary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Generic</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>- Brand-Name Drug</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>• Non-Formulary</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Eligible Medical Expenses for details.</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Rehabilitation Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per admission</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per admission</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Limited to 50% of the Semi-Private Room Charge of the Hospital of prior confinement. Coverage is limited to 90 days per confinement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant-Related Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
ELIGIBLE MEDICAL EXPENSES

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

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

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

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

Abortion: See "Family Planning"

Acupuncture: See "Chiropractic Care / Acupuncture"

Ambulance & Travel: Professional ground ambulance service when used locally to transport a Covered Person to and from a Hospital or Skilled Nursing Facility or to transfer a Covered Person from an out-of-network Hospital to a Network Hospital following stabilization of a Medical Emergency.

- Professional air ambulance service when necessary to transport a Covered Person, in a Medical Emergency, to the nearest stateside (i.e., U.S.) Hospital where necessary treatment can be rendered.
- Travel by train or commercial airline in the continental United States and Canada to, but not returning from, a Hospital for needed special care.

Ambulatory Surgical Center: Services and supplies provided by an Ambulatory Surgical Center in connection with a covered Outpatient surgery, including any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

Anesthesia: Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Attention Deficit Disorders (ADD & ADHD): Education or training for the treatment of attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

Birthing Center: Services and supplies provided by a Birthing Center in connection with a covered Pregnancy, typically a special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- has organized facilities for birth services on its premises;
- provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;
- has 24-hour-a-day registered nursing services;
- maintains daily clinical records.

Blood: Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.
Chemotherapy: Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic Care / Acupuncture: Services of a chiropractor (DC) or acupuncturist (CA).

Circumcision

Convalescent Hospital: See "Skilled Nursing Facility"

Covered Person: An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, a Qualified Beneficiary (COBRA), etc.). See Eligibility and Effective Dates, Extensions of Coverage and the COBRA Continuation Coverage sections for further information. **Note:** In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider: Any practitioner of the healing arts who:

- is licensed and regulated by a state or federal agency and is acting within the scope of his or her license; or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

- Acupuncturist (CA)
- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor (DC)
- Dentist (DDS or DMD)
- Dietician
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Nurse Practitioner
- Occupational Therapist (OTR)
- Optometrist (OD)
- Physical Therapist (PT or RPT)
- Physician - see definition of "Physician"
- Physician Assistant (PA)
- Podiatrist or Chiropractor (DPM, DSP, or DSC)
- Registered Nurse (RN)
- Respiratory Therapist
- Speech Pathologist

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

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;
- tuberculosis hospitals;
- freestanding public health facilities;
- hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- enuresis control centers;
- prosthetists and prosthetist-orthotists;
- portable X-ray companies;
- independent laboratories and lab technicians;
- diagnostic imaging facilities;
- blood banks;
- speech and hearing centers;
- ambulance companies.

A Covered Provider does not include:

- a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of General Exclusions, or
- any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Diagnostic Lab & X-ray, Outpatient: Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis: See "Medical Equipment & Supplies"
Durable Medical Equipment: See "Medical Equipment & Supplies" and "Prosthetics"

Emergency: See "Medical Emergency"

Family Planning: Family planning services include, but are not limited to:

- consultation by a Physician;
- sterilization procedures (a tubal ligation for a woman or a vasectomy for a man) – see Note;
- elective abortion;
- infertility testing and counseling;
- contraceptive devices (IUDs / implants); and
- diaphragm fitting.

Note: Reconstruction (reversal) of a prior elective sterilization procedure is not covered. Infertility treatment is not covered.

Hearing Exams & Tests: Hearing exams and hearing tests.

Hearing Aids: Hearing aids and the fitting of hearing aids. Important: This benefit is not covered for enrollees in the La Nueva Frontera Option.

Home Health Care: Services and supplies that are Eligible Medical Expenses as otherwise defined herein and that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person's attending Physician in lieu of a continued Hospital confinement and must be monitored by the Physician during the period of home health care. The attending Physician must certify that the condition would require continued inpatient confinement in a Hospital in the absence of home health care. Home health care services and/or supplies must be provided through a Home Health Care Agency.

Eligible home health care expenses will not include:

- custodial care, unless provided by a home health aide;
- transportation services;
- services of someone who lives with the patient;
- services not included in the written home care plan of the Physician of record;
- services rendered at a time when the patient is not under the care of the Physician who set up the home care plan;
- excluded services and supplies – see the list of Medical Limitations and Exclusions.

Important: This benefit is not covered for enrollees in the La Nueva Frontera Option.

Home Health Care Agency: An agency or organization that:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;
- provides for full-time supervision of its services by a Physician or by a registered nurse;
- maintains a complete medical record on each patient;
- has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice Care: Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care upon the written recommendation of his attending Physician. Eligible Expenses include Hospice program charges for:

- palliative care (i.e., care that is rendered to relieve the symptoms or effects of a Sickness without curing the Sickness);
- custodial care;
- medical social services; and
- respite care (i.e., Inpatient care provided to the patient to temporarily relieve the family or regular non-professional caregivers from the stress of caring for the patient).
Hospice care also includes bereavement counseling sessions for members of the immediate family within twelve (12) months following the death of the Covered Person.

Eligible Hospice care expenses will not include:

- services provided by persons who do not regularly charge for their services;
- counseling which is not provided as part of the Hospice care plan;
- services provided by homemakers, caretakers and the like;
- funeral expenses;
- treatment intended to cure the terminal illness.

**Important:** This benefit is not covered for enrollees in the La Nueva Frontera Option.

**Hospice or Hospice Agency:** An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

**Hospital:** A place which meets all of the standards below:

- has permanent and full-time care for bed patients;
- is under the supervision of a Physician;
- has a registered nurse (RN) on duty or call 24-hours-a-day;
- is mainly engaged in giving medical care and services for injuries or illness but not including a rest home, nursing home, convalescent home, or home for the aged;
- has surgical facilities except that this standard does not apply to such place operated mainly for treatment of the chronically ill;
- is operated lawfully in its area.

**Inpatient:** A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

**Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit or Intermediate Care Unit:** A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

**Hospital Services:** Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies. Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at an out-of-network Hospital, to the Semi-Private Room Charge or 3 times the Hospital’s average semi-private room charge for an Intensive Care Unit. **Note:** The emergency room Capay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.

**Infertility Testing:** See "Family Planning"

**Medical Emergency:** An Accidental Injury or the sudden onset of a medical condition, including severe pain, that is of sufficient severity that the absence of immediate medical attention would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required and that lack of such care could reasonably result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

**Medical Equipment & Supplies:** Rental of medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be Medically Necessary, prescribed by a Physician and required for therapeutic use in treatment of a Sickness, Accidental Injury or a disabling congenital condition.
"Medical equipment" means items that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home. Such items include, but are not limited to:

- traction apparatus, head halters, cervical collars, trusses or braces;
- oxygen and dialysis equipment and supplies and maintenance, including training in the use of such equipment;
- glucometers, dextrometers, dextrostix, infusion pumps;
- crutches, canes, walkers, wheelchairs and hospital beds and adaptive equipment or modifications to wheelchairs or hospital beds when prescribed by a Physician as necessary for the treatment of the Accidental Injury or Sickness.

Medical supplies including casts, orthopedic spints, ostomy bags and supplies, burn pressure garments or dressings, surgical dressings, and an initial post-mastectomy holding bra. The purchase or rental of luxury equipment (e.g., motorized wheelchairs or other vehicles) is not covered when standard equipment is appropriate for the patient's condition. Nerve stimulators, orthopedic shoes, corrective devices for shoes, support hosiery, bandages, diapers, formula, etc. are not covered.

Medically Necessary: Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

- it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;
- the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
- it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and
- it is provided at the most appropriate level of care needed to treat the particular condition.

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

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicines: Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. See "Prescription Drugs, Outpatient" in the Medical Benefit Summary for pharmacy drugs. Important: The "Catastrophic Option" does not include benefits for Outpatient prescription drugs.

Mental Health/Substance Use Disorder Care: Treatment of mental health conditions and substance use disorder.

**NOTICE:** Mental Health and Substance Use Disorder Benefits are provided ONLY through the Hoiman Group; see Important Numbers and Website Address for claim and benefit questions, as well as for contact information.

For plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence, including attention deficit disorder and autism or as otherwise defined in accordance with applicable Federal and State law. Benefits also cover counseling for marital or family problems. Important: These benefits are not covered for enrollees in the La Nueva Frontera Option.

Midwife: Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

Newborn Care: Eligible Medical Expenses, as listed herein, that are provided to a covered newborn child who requires treatment for a Sickness or Accidental Injury. If Pregnancy benefits are available under the Plan, a newborn's care during the first 14 days after birth will be treated as expenses incurred by the mother. See "Pregnancy Care" for information.
**Nursing Services, Private Duty:** Services of a registered nurse (RN) or licensed practical nurse (LPN) for private duty nursing services and nursing supplies used by the nurse to treat the patient's sickness or accidental injury. Nursing care must be prescribed in writing by the patient's attending physician, and the treatment plan must be updated every 30 days. Private-duty nursing care must be provided on an outpatient basis and in lieu of an inpatient hospital stay or to avoid a hospital or skilled nursing facility stay.

Private duty nursing services are not covered for:

- custodial care;
- services not included in the physician's written treatment plan, or
- any services or supplies that are excluded (see the list of Medical Limitations and Exclusions).

**Occupational Therapy:** See "Therapy, Outpatient"

**Orthotics:** See "Medical Equipment & Supplies"

**Oxygen:** See "Durable Medical Equipment"

**Physical Therapy:** See "Therapy, Outpatient"

**Physician:** A medical practitioner licensed to perform surgery and administer drugs acting in the scope of that license. A physician will also include any other licensed practitioner of the healing arts who is acting within the scope of his/her license and is performing a service for which benefits are provided under the plan.

*Note:* A "physician" will not include the covered person himself, his relatives (see General Exclusions) or interns, residents, fellows or others enrolled in a graduate medical education program.

**Physician Services:** Medical and surgical treatment by a physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "second & third Surgical Opinion" below for requirements applicable to surgery opinion consultations.

- An "office visit" includes all covered services performed at the time of the visit.
- A "primary care physician" is a family physician, general practitioner, internist, pediatrician, or OB/GYN who acts as the covered person's personal physician.

*Note:* Charges made by a physician for time on "standby" status when no actual service is rendered are not covered.

**Podiatry Services:** Foot care services including removal of plantar warts and removal of nail roots and treatment of feet necessitated by metabolic or peripheral-vascular disease affecting the lower extremities. *Note:* In general, the plan will not cover routine foot care (hygiene services, treatment of flat feet or other structural foot problems, treatment of corns, calluses, or warts) other than those services specifically addressed above.

**Pre-admission testing:** Lab tests and X-rays performed on an outpatient basis within 3 days before a scheduled hospital admission.

**Pregnancy Care:** Eligible pregnancy-related expenses of a covered person. Eligible expenses include the following, are covered at least to the same extent as any other sickness, and may include other care that is deemed to be medically necessary by the patient's attending physician:

- pre-natal visits and routine pre-natal and post-partum care;
- expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;
- genetic testing or counseling when deemed medically necessary by a physician;
- newborn care provided during the first fourteen (14) days after birth.

In accordance with the newborns' and mother's health protection act, the plan will not restrict benefits for a newborn hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the utilization management program requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending physician and the mother.
Prescription Drugs: Drugs and medicines that are dispensed and administered to a Covered Person during an inpatient confinement or during a Physician's office visit. Prescription drug coverage involves a program through an independent vendor. Important: The "Catastrophic Option" does not include benefits for Outpatient prescription drugs.

There are two ways to fill a prescription:

- **Retail:** A prescription can be purchased at a participating pharmacy in up to a 30-day supply for the Copays shown in the Medical Summary of Benefits.

- **Mail Order:** A maintenance drug can be obtained through the home delivery program and can be obtained in up to a 90-day supply for the Copays shown in the Medical Summary of Benefits.

There are two types of prescription available:

- **Formulary:** The formulary is a preferred list of the most commonly prescribed medications that have been selected by doctors, pharmacists and other healthcare professionals. The formulary includes brand-name and generic medications that have been approved by the FDA as safe and effective. The medications listed on the formulary are clinically equivalent and possibly more cost effective than other non-formulary medicines.
  
  o **Generic:** When a patent on a brand-name medicine expires, the generic equivalent can be made by other manufacturers without the initial start-up costs. As a result, the medicines can be made available to consumers, with the identical chemical composition of the equivalent brand-name medicine, at much lower costs.

  o **Brand Name:** Brand-name medicines are manufactured by a company under a registered trademark. Medications are generally more expensive due to the research, development and marketing that is required for introducing a new medicine to the public.

The formulary applies only to prescription medications dispensed to patients by participating pharmacies. The formulary does not apply to inpatient medications or to medications obtained from, and/or administered by, a physician.

- **Non-Formulary:** Non-formulary medications are not preferred for coverage by the carrier and as a result, require a higher copayment.

The Plan's preexisting condition restrictions do not apply to prescription purchases. In addition, prescriptions written by a Frontera provider must be filled in Mexico.

Prescriptions written by a Stateside provider must be filled in the U.S. Prescriptions can only be filled in the country where it was written.

- **Specialty Pharmacy Program:** This program covers certain drugs commonly referred to as high-cost specialty drugs. Such drugs must be obtained by mail through a special pharmacy (a pharmacy which dispenses high cost specialty drugs). The way the prescription is written by the Physician (i.e., 30-day supply or 90-day supply) will dictate the Copay amount. If a specialty drug is dispensed by a non-participating pharmacy, charges in excess of Usual, Customary and Reasonable are not covered and will be the responsibility of the Covered Person.

- **Prior Authorization:** Certain drugs must receive prior authorization for Medical Necessity. A list of drugs which require prior authorization may be obtained from the Plan Sponsor or the prescription vendor. A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor.

The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's personnel office or the office of the Plan Sponsor.

A brief summary of what drugs are and are not covered by the plan are described on the following page.
Prescription Drugs, continued

- **Covered Drugs** include most prescription drugs (i.e., federal legend drugs and compounded drugs that are prescribed by a Physician and that require a prescription either by federal or state law) and certain non-prescription items. The following is a list of prescription and non-prescription drugs and supplies that are sometimes excluded by group health plans but that are covered by this Plan. In some instances, coverage may be subject to prior authorization for the following:
  - Attention Deficit Hyperactivity Disorder (Adderall and Ritalin)
  - Contraceptives: Oral contraceptives (birth control pills) and diaphragms.
  - Cosmetic Agents: Retin-A, Avita, Renova and Differin for treatment of acne up to age 26
  - Diabetic Supplies: Glucose strips, alcohol swabs, lancets, and insulin needles and syringes.
  - Impotence Drugs: Limited to 6 tablets per 30-day period.
  - Injectable Insulin
  - Smoking Cessation ($350 lifetime maximum).
  - Weight Management Drugs ($350 lifetime maximum).

- **Expenses not covered by the prescription drug plan:**
  - Administration: Any charge for the administration of a covered drug.
  - Blood, Blood Plasma & Biological Sera
  - Cosmetic Drugs: Health or beauty aids.
  - Delivery Charges
  - Devices: Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
  - Excess Refills: Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.
  - Experimental & Non-FDA Approved Drugs: Experimental drugs and medicines, even though a charge is made to the Covered Person. Drugs not approved by the Food and Drug Administration.
  - Healing Devices
  - Immunizations Agents: Serums, toxoids, vaccines.
  - Injectables & Supplies: Injectables or any prescription directing administration by injection (other than insulin).
  - Hypodermic syringes and/or needles for the administration of injectables, except as may be expressly included.
  - Investigational Drugs: A drug or medicine labeled: "Caution – limited by federal law to investigational use."
  - New Drugs: Drugs to market less than one (1) year. Some exceptions will be made with prior authorization.
  - No Charge: A prescribed drug that may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers’ compensation or occupational disease law.
  - Non-Home Use: Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.
  - Non-Prescription Drugs: A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
  - Organic Serum
  - Vitamins & Minerals: Prescription or non-prescription vitamins, except for prenatal vitamins.
Preventive Care: Certain preventive services that are provided in the absence of sickness or injury. Important: The "La Nueva Frontera Option" does not include Preventive Care benefits. Preventive Care includes:

- 1 routine well-adult physical exam each Calendar Year including related lab work, X-rays and immunization and inoculations;
- 1 well-woman exam each Calendar Year including a pap smear;
- mammograms, subject to the following age and frequency guidelines:
  - 1 baseline mammogram for women age 35 through 39
  - 1 screening mammogram each Calendar Year for women age 40 and over or more frequently based on a Physician’s recommendation
  - 1 screening mammogram for any woman who is at risk for breast cancer because of family history, upon recommendation of a Physician
- age appropriate colonoscopy as described by the American Medical Association Guidelines;
- one prostate screening (PSA) per Calendar Year;
- well child check-ups (including developmental assessment, anticipatory guidance and diagnostic tests), immunizations and inoculations at the frequencies recommended by the American Pediatric Standards, and school/camp/sports exams which includes immunizations, inoculations and diagnostic tests.

Note: Immunizations and inoculations for foreign travel are not covered.

Prosthetics: Man-made limbs or eyes to replace natural limbs or eyes. Post-mastectomy breast prostheses. Adjustment, repair or replacement of a prosthetic device, surgical implant or special appliance when required because of wear or a change in the patient's condition. Note: Excess charges for luxury equipment (e.g., bionic or computerized limbs) are not covered when standard equipment is appropriate for the patient's condition.

Radiation Therapy: Radium and radioactive isotope therapy.

Rehabilitation Hospital: Medically Necessary confinement in a Rehabilitation Hospital or specialized facility (e.g., a tuberculosis hospital). A place that:

- provides care 24-hours-per-day by a Physician or an RN to registered inpatients;
- has available at all times a Physician who is a staff member of an acute care Hospital;
- has an RN on duty at least 8 hours per day;
- maintains a daily medical record for each patient;
- complies with licensing and other legal requirements;
- is not, other than incidentally, a place for custodial care, a palace for the aged, a place for the care of persons addicted to or dependent on a drug or chemical emotional disorder, a place of rest, or nursing home, a hotel or similar institution.

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

Second (3rd) Surgical Opinion: A second surgical opinion consultation following a surgeon’s recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Semi-Private Room Charge: The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 80% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness: Sickness will mean bodily illness or disease (other than mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.
Skilled Nursing Facility: Inpatient care in Skilled Nursing Facility, but only when the admission to the facility or center is Medically Necessary and:

- is preceded by confinement of at least three (3) days in a Hospital, is for the same condition causing the preceding Hospital confinement and occurs within seven (7) days of discharge from such prior confinement; or
- occurs within three (3) days of discharge from a prior Skilled Nursing Facility confinement for the same condition.

An institution that:

- can provide permanent full-time care for ten (10) or more resident patients;
- has a Physician who prescribes medications and treatment;
- has an RN on full-time duty in charge of patient care;
- has LPNs or LVNs on duty at all times under the supervision of an RN;
- keeps a daily medical record for each patient;
- is not mainly a rest home or a home for custodial care of the aged and is not mainly engaged in treatment of drug addicts or alcoholics;
- is operating lawfully as a nursing home.

Speech Therapy: See “Therapy, Outpatient”

Sterilization Procedures: See “Family Planning”

Therapy, Outpatient: The following therapy services provided on an Outpatient basis:

- occupational therapy by a registered/certified occupational therapist to restore physical function;
- physical therapy by a registered physical therapist;
- speech therapy by a certified speech therapist to restore speech loss, correct an impairment due to a congenital defect for which corrective surgery has been performed, or to correct an impairment caused by an Accidental Injury or Sickness (not caused by a mental, psychoneurotic or personality disorder).

For therapy services provided in the patient’s home, see “Home Health Care.”

TMJ / Jaw Joint Treatment: Surgical and non-surgical services and supplies for treatment of temporomandibular joint dysfunction (TMJ).

Transplant and Related Expenses: The Plan Sponsor provides transplant coverage through a separate fully-insured product. See “Note” below for details about that coverage. Important: These benefits are not covered for enrollees in the La Nueva Frontera Option.

Where transplant benefits are not provided to a Covered Person under the fully-insured product for any reason, then Eligible Expenses incurred by a Covered Person who is the recipient of a transplant that is not experimental or investigational in nature will be covered under these medical benefits of the Plan, subject to the following conditions:

- when the transplant recipient and the donor are both Covered Persons, benefits will be provided for both under the recipient’s coverage;
- when only the transplant recipient is a Covered Person, benefits will be provided for Eligible Expenses of the donor to the extent that benefits to the donor are not provided under any other form of coverage;
- when only the donor is a Covered Person, no benefits will be provided for the donor or the recipient.

Notes: An eligible Employee or Dependent requiring human organ and tissue transplant services and for which benefits are available under the AIG Life certificate, will have transplant-related expenses covered under that separate certificate, according to its terms and conditions, from the time of the transplant evaluation through 365 days post transplant operation. After the specified benefit period has elapsed, all transplant-related medical benefits will be subject to the terms and conditions of the medical benefits of this health Plan document. The carve-out benefit does not apply to transplants performed in Mexico.

Except as may be expressly allowed by AIG, the transplant carve-out benefit is available only when performed stateside and by stateside providers.
**Urgent Care Facility:** A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

**Usual, Customary and Reasonable (UCR):** A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate - but not to exceed the actual charge or the out-of-network Usual, Customary and Reasonable allowance unless such lesser amount is not permitted under the terms of the Network agreement.

**Vein Stripping**
MEDICAL LIMITATIONS AND EXCLUSIONS

In addition to those listed in the General Exclusions section, and except as specifically stated otherwise, no benefits will be payable for:

Accidental Injury: Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see General Exclusions section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

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

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

Contraceptives: Chemical Dependency: Services or supplies for treatment of chemical dependency or substance abuse. Benefits may be available through the Employee Assistance Program. Medications, injections, implants, devices or the fitting of devices or any other services or supplies provided for birth control purposes, except as expressly included.

Cosmetic & Reconstructive Surgery, Etc.: Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

▪ services necessitated by an Accidental Injury which interferes with a normal function of the body or causes physical pain, and then limited to treatment provided within one (1) year of the accident;
▪ coverage required by the Women’s Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;
▪ treatment necessary to correct a congenital abnormality (birth defect) which interferes with a normal function of the body or causes physical pain.

Custodial & Maintenance Care: Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, etc.) that could be rendered at home or by persons without professional skills or training. Services or supplies that cannot reasonably be expected to lessen the patient’s disability or to enable him to live outside of an institution. Any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time, except as may be included as part of a formal Hospice care program.

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

▪ treatment of oral tumors;
▪ removal of impacted teeth;
▪ repair or prosthetic replacement of sound natural teeth that are damaged in an Accidental Injury, but limited to services provided within one (1) year of the accident, or
▪ Hospital services and supplies when necessary for dental care.

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

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

Educational or Vocational Testing or Training: Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation. Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs: Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.
Genetic Counseling or Testing: Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a Pregnancy that is covered by the Plan.

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

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

Hypnotherapy: Treatment by hypnotism.

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

Learning & Behavioral Disorders: Except as noted, education or training of any type of treatment for learning disabilities. IQ testing, except in connection with assessment or treatment of a speech, language or hearing disorder. Note: This exclusion does not apply to education or training for the treatment of attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

Maintenance Care: See "Custodial & Maintenance Care"

Nerve Stimulators

Nicotine Addiction: Nicotine withdrawal programs, facilities or supplies.

Non-Prescription Drugs: Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan. In addition, there is no coverage for drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed: Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein. Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Orthognathic Surgery: Surgery to correct a receding or protruding jaw.

Personal Comfort or Convenience Items: Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Preexisting Conditions: See section entitled Special Restrictions for Preexisting Conditions for information

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

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

Sex-Related Disorders: Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.
Thermograms / Temperature Gradient Studies
Vaccinations: Immunizations or vaccinations other than: (1) those included in the "Preventive Care" coverages—see the Medical Benefit Summary, and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Vision Care: Eye examinations for the purpose of prescribing corrective lenses. Vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment. Orthoptics, vision therapy, vision perception training, or other special vision procedures. Surgical correction of refractive error (e.g., radial keratotomy keratectomy, keratoplasty) that could be corrected with glasses or contact lenses. Note: This exclusion will not apply to the initial purchase of glasses or contact lenses following cataract surgery.

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

Vocational Testing or Training: Vocational testing, evaluation, counseling or training.

Weight Control: Services or supplies for obesity, weight reduction or dietary control, except when provided for treatment of morbid obesity. "Morbid obesity" means the Covered Person's body weight exceeds the medically-recommended weight by either 100 pounds or is twice the medically-recommended weight for a person of the same height, age and mobility as the Covered Person.

Wigs or Wig Maintenance: See "Hair Restoration"
GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

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

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

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the CMS Medicare Coverage Issues Manual.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments. Note: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Late-Filed Claims - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the Claims Procedures section.

Military Service - Conditions that are determined by the Veteran’s Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

Never Events: The following list was developed by the National Quality Forum (NQF). Never events are medical errors that should never happen, but when they do, typically cause serious consequences for the patient. By excluding these events, the plan reduces unnecessary costs and eliminates payment for expenses which should not have been incurred. Never events include:

- Surgical Events:
  - surgery performed on the wrong body part,
  - surgery performed on the wrong patient,
  - wrong surgical procedure on a patient,
  - retention of a foreign object in a patient after surgery or other procedure, or
- intraoperative or immediately post-operative death in a normal, healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative).

- Product or Device Events:
  - patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility,
  - patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended, or
  - patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

- Patient Protection Events:
  - infant discharged to the wrong person,
  - patient death or serious disability associated with patient elopement (disappearance) for more than four hours, or
  - patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.

- Care Management Events:
  - patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration),
  - patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products,
  - maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility,
  - patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility,
  - death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates,
  - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, or
  - patient death or serious disability due to spinal manipulative therapy.

- Environmental Events:
  - patient death or serious disability associated with an electric shock while being cared for in a healthcare facility,
  - any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances,
  - patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility,
  - patient death associated with a fall while being cared for in a healthcare facility, or
  - patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.

- Criminal Events:
  - any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider,
  - abduction of a patient of any age,
  - sexual assault on a patient within or on the grounds of a healthcare facility, or
  - death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts. Note: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Plan Administrator.
Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

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

Outside United States – If you are not enrolled in the Comprehensive Plus Frontera or La Nueva Frontera Options, charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies. Note: This exclusion does not apply to care received outside of the United States that is necessary to stabilize a Medical Emergency and allow a Covered Person to return to the United States.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

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

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

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

Sales Tax, Etc. - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

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

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions - Any condition that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not the Covered Person has or had a right to compensation under any Workers’ Compensation or occupational disease law or any other legislation of similar purpose. If the Plan elects to provide benefits for any such condition, the Plan will be entitled to establish a lien upon such other benefits up to the amount paid.
EMPLOYEE ASSISTANCE PROGRAM (EAP)

EAP benefits, provided through the Holman Group, are available to you and your dependents that are enrolled in a medical option offered by ICSVEBA. In order to receive the benefits described in this section, you and/or your dependents must use providers that have contracted with the Holman Group; there is no coverage for out-of-network providers.

Services Available
The EAP provides five free face-to-face confidential counseling sessions each year with a local, licensed therapist for each family, per problem area. The EAP can help with issues relating to:

- marital and family issues,
- adolescent behavior,
- substance abuse,
- stress,
- depression,
- job-related issues,
- emotional difficulties,
- grief,
- legal, and
- much more...

Our EAP also offers:

- A toll-free, nationwide 800 number staffed by licensed therapists available to help you in a crisis (see Important Numbers and Website Addresses).

- A free 30-minute phone consultation with a licensed attorney for each legal matter you encounter. In addition, if you choose to retain the attorney you used during the initial consultation, there is a 25% discount.

- Free phone consultation and referrals to financial management experts throughout the country.

- Unlimited access to a Legal and Financial Services website with:
  - information about almost any legal issue,
  - over 45 different financial calculators, and
  - access to 100% accurate state specific forms.

- Free information about Wills or End of Life documents, Retirement Kits and an Estate Planning Checklist.

- Prescription Drug Discount Card.

- Unlimited access to Holman’s Website which contains wellness related articles and links.

- Unlimited community referrals (i.e., child care, elder care, chemical dependency groups, etc.).

Ongoing or Additional Care
For additional Mental Health/Chemical dependency coverage, see the benefits listed under the medical plan.

Charges for Late Cancel or No Show Appointments
Employees and/or their dependents must notify the providers at least twenty-four (24) hours in advance of the appointment that it will not be kept. Employee and/or their dependents will forfeit one session for any free session not kept.
# Important Numbers and Web Site Addresses

For preauthorization, forms, claims, questions or provider directories, refer to the information below.

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Contact Name and Information</th>
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<tbody>
<tr>
<td><strong>Medical Network</strong>&lt;br&gt;<strong>All locations (other than Corning):</strong>&lt;br&gt;  - Finding In-Network Providers&lt;br&gt;  - Preauthorization</td>
<td><strong>Anthem Blue Cross PPO (Prudent Buyer)</strong>&lt;br&gt;  1-800-274-7767&lt;br&gt; <strong>Arizona Foundation for Medical Care</strong>&lt;br&gt;  1-800-852-8001&lt;br&gt; <strong>La Nueva Frontera</strong>&lt;br&gt;  1-760-429-2878&lt;br&gt;  <a href="http://www.dhsdirect.com">www.dhsdirect.com</a></td>
</tr>
<tr>
<td><strong>Utilization Management Program</strong>&lt;br&gt;Pre-admission and review requirements, etc.</td>
<td><strong>Anthem Blue Cross</strong>&lt;br&gt;  1-800-274-7767&lt;br&gt; <strong>Arizona Foundation for Medical Care</strong>&lt;br&gt;  1-800-852-8001</td>
</tr>
<tr>
<td><strong>Delta TeamCare Health Management Program</strong>&lt;br&gt;A program to assist patients with complex or chronic medical conditions. Delta provides employees with a combination of patient advocacy, self-care education and one-on-one support by experienced health care professionals</td>
<td><strong>Disease Management</strong>&lt;br&gt;  1-800-784-9298&lt;br&gt; Nurses are available Monday – Friday, 7am to 7pm PST&lt;br&gt; <strong>Delta TeamCare</strong>&lt;br&gt;  P. O. Box 629&lt;br&gt;  Stockton, CA 95202-0629&lt;br&gt;  1-800-784-9298&lt;br&gt; <strong>Delta Health Systems</strong>&lt;br&gt;  1-800-556-7256&lt;br&gt;  <a href="http://www.deltahealthsystems.com">www.deltahealthsystems.com</a></td>
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<tr>
<td><strong>Contract Administration for Medical ONLY</strong>&lt;br&gt;Including all:&lt;br&gt;  - Claims Processing&lt;br&gt;  - Eligibility Review&lt;br&gt;  - Benefit Coverage&lt;br&gt;  - Treatment Procedures</td>
<td><strong>The Holman Group</strong>&lt;br&gt;  1-800-321-2943&lt;br&gt;  <a href="http://www.holmangroup.com">www.holmangroup.com</a>&lt;br&gt; <strong>User Name:</strong> holmangroup&lt;br&gt; <strong>Password:</strong> ICS2530 (case sensitive)</td>
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<tr>
<td><strong>Employee Assistance Program</strong>&lt;br&gt;An EAP counselor is available 24 hours a day, 7 days a week for emergency and urgent assistance. To schedule an appointment, receive a community referral, or for inquiries our office is open 7:30 am to 6:30 pm PST.</td>
<td><strong>Satori World Medical</strong>&lt;br&gt;  591 Camino De La Reina, Suite 407&lt;br&gt;  Sand Diego, CA 92108&lt;br&gt;  1-888-613-9688&lt;br&gt;  <a href="http://www.satorworldmedical.com">www.satorworldmedical.com</a></td>
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<td><strong>Mental Health and Substance Use Disorder</strong>&lt;br&gt;Including all:&lt;br&gt;  - Claims Processing&lt;br&gt;  - Eligibility Review&lt;br&gt;  - Benefit Coverage&lt;br&gt;  - Treatment Procedures</td>
<td><strong>Envision</strong>&lt;br&gt;  1-800-361-4542&lt;br&gt;  <a href="http://www.envisionnx.com">www.envisionnx.com</a></td>
</tr>
<tr>
<td><strong>Global Medical Benefit</strong></td>
<td><strong>Hub International Insurance Services Inc.</strong>&lt;br&gt;  1331 Morena Boulevard, Suite 300&lt;br&gt;  San Diego, CA 92110&lt;br&gt;  1-800-533-2083</td>
</tr>
<tr>
<td><strong>Prescription Benefits</strong>&lt;br&gt;Retail and Mail Order</td>
<td><strong>Empire Blue Cross/Blue Shield</strong>&lt;br&gt;  1-800-390-3671&lt;br&gt;  <a href="http://www.ebcbsh.com">www.ebcbsh.com</a></td>
</tr>
<tr>
<td><strong>Benefit Consultants</strong></td>
<td><strong><a href="http://www.benefitconsultants.com">www.benefitconsultants.com</a></strong></td>
</tr>
</tbody>
</table>

Address information for medical, prescription and dental claims are located under *How to File Claims.*
General Information
COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

Definitions
As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides health care benefits or services:
- a group or group blanket plan on an insured basis;
- any other plan that covers people as a group;
- a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
- a pre-payment plan which provides medical, vision, dental or health service;
- government plans, except Medicaid;
- group auto insurance, but only to the extent medical benefits are payable thereunder;
- no-fault auto insurance on an individual basis;
- single or family subscribed plans issued under a group or blanket-type plan.

An "Other Plan" does not include: (1) hospital indemnity-type plans, or (2) school accident type coverage. Notes: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them. If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The coverages of this Plan.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

- If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

- If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

Note: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

Claim Determination Period - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which this Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.
Effect on Benefits Under This Plan

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

Note: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

Order of Benefit Determination Rules
Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

Non-Dependent vs. Dependent - The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

- the plan of the Custodial Parent;
- the plan of the spouse of the Custodial Parent;
- the plan of the noncustodial parent; and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person’s dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

Note: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

Right to Receive and Release Necessary Information
For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment
A payment made under an Other Plan may include an amount that should have been paid under this Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery
If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

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**SUBROGATION AND REIMBURSEMENT PROVISIONS**

Payment Condition
The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Beneficiary”) or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively “Coverage”).

Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan’s name as a copayee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.
Subrogation
As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:
- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker’s compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary’s and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement
The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary’s recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts’ fees, attorneys’ fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, expressed written consent of the Plan. The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Beneficiary.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance - If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan’s benefits shall be excess to:
- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker’s compensation or other liability insurance company; or
• any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

Wrongful Death Claims - In the event that the Plan Beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply.

Obligations - It is the Plan Beneficiary’s obligation:

• to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan’s rights;
• to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
• to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
• to do nothing to prejudice the Plan’s rights of subrogation and reimbursement;
• to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
• to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money from the Plan Beneficiary.

Offset - Failure by the Plan Beneficiary and/or his or her attorney to comply with any of these requirements may, at the Plan’s discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status - In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned. If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

Language Interpretation - The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan’s subrogation and reimbursement rights. The Plan Administrator may amend the Plan at anytime; however Employees will be provided with advance notice of the change(s), as required by federal law.

Severability - In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.
CLAIMS PROCEDURES

Submitting a Claim
A claim is a request for a benefit determination that is made, in accordance with the Plan’s procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the Utilization Management Program section for that information.

   Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. Notice of a Post-Service claim must be provided to the claims office within twelve (12) months after it occurs. Proof of a Post-Service Claim must be submitted to the claims office within fifteen (15) months from the date a covered expense is incurred. A Post-Service Claim should be submitted to:

   Delta Health Systems
   3244 Brookside Road, Suite 200
   Stockton, CA 95219

   Note: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

Assignment to Providers
All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action he may have against the Plan or its fiduciaries.

Note: Benefit payments on behalf of a Covered Person who is also covered by a state’s Medicaid program will be subject to the state’s right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state’s having paid Medicaid benefits that were payable under the Plan.
# CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond, etc.).

**Important:** These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

<table>
<thead>
<tr>
<th>&quot;PRE-SERVICE&quot; CLAIM ACTIVITY</th>
<th>TIME LIMIT OR ALLOWANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Claim</strong> - defined below</td>
<td><strong>Claimant Makes Initial Incomplete Claim Request</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Plan Receives Completing Information</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Claimant Makes Initial Complete Claim Request</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Claimant Appeals</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Plan Responds to Appeal</strong></td>
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</table>

An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, considering the urgency of the medical situation.

| **Concurrent Care Claim** - defined below | **Plan Wants to Reduce or Terminate Already Approved Care** | Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary is subject to the urgent claim rules. |
| **Claimant Requests Extension for Urgent Care** | Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate. |

A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.
### Non-Urgent Claim

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Limit or Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimant Makes Initial <strong>Incomplete</strong> Claim Request</td>
<td>Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.</td>
</tr>
<tr>
<td>Plan Receives <strong>Completing</strong> Information</td>
<td>Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Makes Initial <strong>Complete</strong> Claim Request</td>
<td>Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Appeals</td>
<td>See &quot;Appeal Procedures&quot; subsection.</td>
</tr>
<tr>
<td>Plan Responds to Appeal</td>
<td>Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).</td>
</tr>
</tbody>
</table>

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.

### "POST-SERVICE" CLAIM ACTIVITY

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Limit or Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimant Makes Initial <strong>Incomplete</strong> Claim Request</td>
<td>Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.</td>
</tr>
<tr>
<td>Plan Receives <strong>Completing</strong> Information</td>
<td>Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Makes Initial <strong>Complete</strong> Claim Request</td>
<td>Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Appeals</td>
<td>See &quot;Appeals Procedures&quot; subsection.</td>
</tr>
<tr>
<td>Plan Responds to Appeal</td>
<td>Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).</td>
</tr>
</tbody>
</table>

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.
Authorized Representative May Act for Claimant
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant’s behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant’s medical condition, will be permitted to act as the authorized representative of the Claimant. “Health care professional” means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

Claims Denials
If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial within the time frames required by law - see “Claims Time Limits and Allowances.” The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- the specific reason(s) for the decision to reduce or deny benefits;
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant’s claim for benefits;
- a description of any additional information needed to change the decision and an explanation of why it is needed;
- a description of the Plan’s procedures and time limits for appealed claims, including a statement of the Claimant’s right to bring a civil action under section 502(a) of ERISA.

Appeal Procedures

Filing an Appeal
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan’s mandatory (i.e., non-voluntary) appeal procedures - see Note.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A “full and fair review” takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

Note: In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see “Claims Time Limits and Allowances.”

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the decision;
- reference to the pertinent Plan provisions on which the decision is based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;
- a statement describing any voluntary appeal procedures offered by the Plan, the Claimant’s right to obtain the information about such procedures, and a statement of the Claimant’s right to bring an action under ERISA section 502(a).
**GENERAL PLAN INFORMATION**

<table>
<thead>
<tr>
<th>Plan Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Plan</strong></td>
<td>Welfare Benefit Plan for Employees of Imperial County Schools Voluntary Employees Benefits Association</td>
</tr>
<tr>
<td><strong>Plan Sponsor</strong></td>
<td>Imperial County Schools VEBA 1398 Sperber Road, El Centro, CA 92243 1-760-312-6440</td>
</tr>
<tr>
<td><strong>Type of Plan</strong></td>
<td>The Plan is a welfare benefit plan subject to the Health Insurance Portability and Accountability Act (HIPAA)</td>
</tr>
</tbody>
</table>
| **Participants** | Calipatria Unified School District  
El Centro Elementary School District  
Heber Elementary School District  
Imperial County Office of Education  
Imperial Valley College  
Imperial Valley ROP  
Magnolia School District  
McCabe Union School District  
Meadows Union School District  
Mulberry School District  
San Pasqual Valley Unified School District  
Seeley Union School District |
| **Plan Year** | October 1 through September 30 |
| **Benefit Year** | Based on a Calendar Year: The period of time commencing at 12:00 A.M. on January 1 of each year and ending at 11:59 A.M. on the following December 31. |
| **Plan Benefits** | Medical and Prescription Benefits |
| **Named Fiduciary** | Imperial County Schools VEBA 1398 Sperber Road, El Centro, CA 92243 1-760-312-6440 |
| **Agent for Service of Legal Process** | Imperial County Schools VEBA 1398 Sperber Road, El Centro, CA 92243 1-760-312-6440 |
| **Privacy Officer and Contact for Privacy Questions** | Superintendent 1-760-312-6440 |
| **Applicable Collective Bargaining Agreement(s)** | None |
| **Bargaining Agreements** | None |
| **Contract Administrator** | Delta Health Systems 3244 Brookside Road, Suite 200 Stockton, CA 95219 1-800-422-6099 |

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

**Employee & Employer Obligations**
Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the COBRA Continuation Coverage section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

**Taxes**
Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

*Note:* To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions that are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner that is consistent with ERISA guidelines.

Administrative Provisions

**Administration (type of)**
Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

**Alternative Care**
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

**Amendment or Termination of the Plan**
Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- determine eligibility for benefits or to construe the terms of the Plan;
- reduce, modify or terminate retiree health care benefits under the Plan, if any;
- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, provided however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan. In addition, Employees will be provided with advance notice of the change(s), as required by federal law.
Note: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see Claims Procedures section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates
Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the
interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party’s control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan’s mandatory claim appeal(s) are exhausted. See the Claims Procedures section for more information.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee’s cessation of active service for the employer;
- a Plan participant’s failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan’s eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those that would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104-3(d)(3) of the regulations.
Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence),
- claims experience,
- receipt of health care,
- medical history,
- evidence of insurability,
- disability, or
- genetic information.

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the terms of its authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply
To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.
Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud
An individual's Plan coverage or eligibility for coverage may be terminated if:

- The individual submits any claim that contains false or fraudulent elements under state or federal law.
- A civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law.
- An individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation insurance laws or similar legislation.
COBRA CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when medical coverage stops, you or your covered dependents may be eligible to continue your benefits at your own expense for a temporary period. To be eligible, you and your covered dependents must:

- experience a qualifying event that causes the loss of coverage, and
- make an election to continue coverage within 60 days of the date shown at the top of the COBRA notification letter (see Applying for Coverage).

The following chart lists qualifying events, who is eligible to continue medical coverage and how long benefits may continue.

<table>
<thead>
<tr>
<th>Qualifying Event (The reason coverage stopped)</th>
<th>Who May Continue</th>
<th>Longest Period of Continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment stops for any reason other than gross misconduct</td>
<td>You and your eligible dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>
| You no longer meet eligibility requirements  
See Who Is Eligible for more information | You and your eligible dependents | 18 months |
| You divorce or legally separate                | Ex-spouse and/or eligible dependent children | 36 months |
| Your dependent children no longer meet the eligibility requirements | Former eligible dependents | 36 months |
| You become entitled to Medicare                | Eligible dependents | 36 months |
| You die                                        | Eligible dependents | 36 months |

A qualified beneficiary is:

- you, your spouse and dependent child(ren) enrolled for medical coverage immediately before the qualifying event, and
- a child born, adopted or placed for adoption during the COBRA coverage period.

Qualified beneficiaries who purchase COBRA coverage are able to make changes to their medical coverage during the annual benefits enrollment period. However, if you had only single coverage in effect when you became eligible for COBRA coverage, you may not change to family coverage until the next annual enrollment period unless you experience an event that would allow you to change your coverage during the year (see Changing Coverage During the Year for more information).

The benefits provided under COBRA continuation coverage will be the same as those provided to eligible employees, spouses or eligible children who are covered under a company plan. If the plans change, benefits under COBRA continuation coverage will also change.

**Important:** If a COBRA election is not made within the 60-day election period, COBRA coverage will not be available.
Multiple Qualifying Events

A disabled individual, and all other covered dependents, may continue coverage for an additional 11 months, for up to a total of 29 months, if an employee or a dependent is disabled (as defined by the Social Security Administration) within 60 days of a qualifying event and notifies the company within 60 days of the latest of the date:

- of determination,
- of the qualifying event,
- coverage is lost, and
- the date the qualified individual is informed of the obligation to provide a notice of disability determination.

If the Social Security Administration determines that the disability no longer exists, you or your dependents must notify your Human Resources representative within 31 days. During the extra 11-month period of coverage, premiums may be increased up to 150% of the regular cost of coverage.

If coverage is continued because of a qualifying event for which the continuation period is 18 months, this 18-month period can be extended to 36 months, in the event of a second qualifying event that provides for up to 36 months of extended coverage. For example, an employee terminates employment and purchases continuation coverage for his family for up to 18 months. Two months later, one of his children reaches the maximum eligibility age. That former dependent child can now purchase continuation coverage for 34 months (36 months minus the two months already received).

If the second qualifying event is that you have become entitled to Medicare, eligible dependents can continue coverage up to 36 months from the date of the first qualifying event.

Applying for Coverage

If one of your dependents loses coverage due to your divorce or legal separation or a dependent no longer meets the eligibility requirements, it is your or your dependent’s responsibility to notify the company and make an election within 60 days of the event.

Notice for the qualifying events described above must be sent in writing (describing the qualifying event and the date it occurred) to:

Delta Health Systems
Eligibility Department
3244 Brookside Road, Suite 200
Stockton, CA 95219

Contact Delta Health Systems at 1-800-422-6099 with any questions regarding the above procedures.

In the event of your termination, reduction in your work hours or death, the company must notify the COBRA Administrator of the qualifying event within 30 days of any of these events. The COBRA Administrator has 14 days to send you a more detailed COBRA Election Notice and Application. To continue coverage under COBRA, you must complete and return the application to the Administrator within 60 days from the later of the date the application is sent to you or the date your coverage would otherwise terminate.

Important: The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.
Cost of Coverage
If you or your dependents choose to continue coverage, you will have to pay the full cost of the coverage plus 2% for administrative costs. Your contributions are due on the first of each month. Your first contribution payment is due within 45 days of the date you elect COBRA coverage. There is a 31-day grace period for payment of regularly scheduled premiums. If the premium is not paid before the expiration of the grace period, COBRA benefits will end and may not be reinstated.

When COBRA Coverage Ends
Continuation coverage will stop before the maximum continuation period shown at the beginning of this section if one of the following events occurs:

- you or your dependents fail to make timely payments,
- you or your dependents become entitled to Medicare,
- you or your dependents reach your maximum period allowed under COBRA,
- coverage starts under another group health plan, unless coverage is delayed or denied because of a pre-existing condition limitation and you do not have creditable coverage to offset the pre-existing condition, or
- the company discontinues all medical, prescription and dental benefit plans offered to employees.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election, etc.), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Legislation relating to COBRA occasionally changes. This Plan will remain in compliance with all applicable laws or any future Internal Revenue Services (IRS) guidance, even if it conflicts with Plan provisions.

Effect of the Trade Act
In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be “Qualified Health Insurance” pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation (“PBGC”), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Definitions:

- **Non-Electing TAA-Eligible Individual**: A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

- **TAA-Eligible Individual**: An eligible TAA recipient and an eligible alternative TAA recipient.

- **TAA-Related Election Period**: With respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

- **TAA-Related Loss of Coverage**: Means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.
Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual’s TAA-Related Election Period.

**HIPAA Creditable Coverage Credit**
With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Non-electing TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan’s preexisting condition exclusion provision.

**Applicable Cost of Coverage Payments**
Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.
Adoption
The Plan Sponsor hereby adopts this document on the date shown below.

This document replaces any and all prior statements of the Plan benefits that are described herein and in that respect this document is adopted as the Benefit Document.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participants
Participants in this Plan are as stated in the section entitled General Plan Information.

The Plan Sponsor may act for and on behalf of any and all of the Participants in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Participants.

Restatement / Replacement of Benefits
This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of October 1, 2010

Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA)

Name: Anne J. Mallory          Title: County Superintendent

Signature: [Signature]         Date: 1/03/11