

*BUTTE SCHOOLS
SELF-FUNDED
PROGRAMS*

BlueCard Plan

Blue Plan

July 1, 2007

Summary Plan Description

Dear Plan Member:

This Summary Plan Description provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Employees and covered dependents (“beneficiaries”) are referred to in this booklet as “you” and “your”. The *plan administrator* is referred to as “we”, “us” and “our”.

All italicized and capitalized words have specific definitions. These definitions can be found in the DEFINITIONS section of this booklet.

Please read this Summary Plan Description (“*plan description*”) carefully so that you understand all the benefits your *plan* offers. Keep this Summary Plan Description handy in case you have any questions about your coverage.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to BC Life & Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the *plan* will be acknowledged in writing, together with a description of how the *plan* proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Claims Administered by:

BLUE CROSS OF CALIFORNIA

on behalf of

BC LIFE & HEALTH INSURANCE COMPANY

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TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS PLAN DESCRIPTION ENTITLED DEFINITIONS.

Participating Providers. There are two kinds of *participating providers* in this *plan*:

- **PPO Providers** are primarily *hospitals* and *physicians* who participate in a BlueCard PPO network and have agreed to provide PPO members with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers.
- **Traditional Providers** are providers who might not participate in a BlueCard PPO network, but have agreed to provide PPO members with health care services at a discounted rate.

The level of benefits we will pay under this *plan* is determined as follows:

- If your *plan* identification card (ID card) shows a PPO suitcase logo and:
 - You go to a PPO Provider, you will get the higher level of benefits of this *plan*.
 - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this *plan*.
- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this *plan*.

Please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in your area. A directory of PPO Providers is available. You can get a directory from your plan administrator (usually your employer).

Non-Participating Providers. *Non-participating providers* are *hospitals* and *physicians* which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the *negotiated rates* and other provisions.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* covers expense you incur from them when they're practicing within their specialty the same as it would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*.

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities, such as skilled nursing facilities, or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of the Prudent Buyer Plan provider network.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

SUMMARY OF MEDICAL BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED MEDICALLY NECESSARY AS DEFINED IN THE PLAN DESCRIPTION. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS A COVERED EXPENSE. CONSULT THIS PLAN DESCRIPTION OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS PLAN DESCRIPTION, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire *plan description* for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans. The benefits of this *plan* may also be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTY section.

Important Note About Covered Expense And Your Co-Payment: *Covered expense* for *non-participating providers* is significantly lower than what providers customarily charge. (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.) You must pay all of this excess amount in addition to your Co-Payment.

MEDICAL BENEFITS

DEDUCTIBLES

Benefit year Deductibles

- Individual Deductible **\$250**
- Family Deductible **\$500**

CO-PAYMENTS

You will be responsible for the following percentages of *covered expense* you incur:

For *mental or nervous disorders* and *substance abuse*:

- Inpatient *hospital* services for treatment of *mental or nervous disorders* and *substance abuse*, and outpatient *day treatment center* services for treatment of *mental or nervous disorders* **20%***
- Inpatient and outpatient *physician's* visits for treatment of *mental or nervous disorders* and *substance abuse* **50%***

For all other *covered expense* incurred **20%****

*In addition to the Co-Payment shown above, you will be required to pay any amount in excess of *covered expense* for the services of a *non-participating provider*.

**Exceptions:

- Each time you visit an emergency room for treatment you will be responsible for paying a co-payment of **\$50**. The Co-payment will be waived if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment. In addition, this Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You will be responsible for charges which exceed *customary and reasonable charge* or *reasonable charge*.
 - a. *Emergency services* provided by other than a *hospital*;

- b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Co-Payment will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in our judgment, cannot be safely moved);
 - c. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* (see MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM);
 - d. Charges by a type of *physician* not represented in a Blue Cross and/or Blue Shield Plan (for example, an audiologist); or
 - e. Cancer Clinical Trials.
- Your Co-Payment for office visits to a *physician* who is a *participating provider*, for treatment for other than *mental or nervous disorders* or substance abuse, will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.
 - Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will be **\$15**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for *covered expense* you incur during a *benefit year*, you will no longer be required to pay a Co-Payment for the remainder of that *year*, but you remain responsible for costs in excess of *covered expense*.

- *Individual*..... **\$ 500**
- *Family* **\$1,000**

***Exceptions:**

- Any Co-Payments you make for emergency room services will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment even after you have reached that amount.
- Any Co-Payments you make for the treatment of *mental or nervous disorders* or substance abuse will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such treatment even after you have reached that amount.

- Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

MEDICAL BENEFIT MAXIMUMS

The *plan* will pay for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- Covered *skilled nursing facility* care **100 days**
per *benefit year*

Home Health Care

- For covered home health services **100 visits**
per *benefit year*

Hospice Care

- For all covered outpatient *hospice* care (including bereavement counseling)..... **100 days**
per *lifetime*

Home Infusion Therapy

- All covered services and supplies received during any one day **\$600***

**Non-participating providers only*

Mental or Nervous Disorders or Substance Abuse

- For covered *physician's* services:
 - *Participating Provider*..... **\$50**
per visit
 - *Non-Participating Provider*..... **\$25**
per visit
- Inpatient *hospital* treatment of *mental or nervous disorders* ... **30 days**
per *benefit year*

Routine Physical Exam (Subscriber & Spouse Only)

- For all covered services.....**\$250**
per *benefit year*

Physical Therapy, Physical Medicine and Occupational Therapy

- For covered outpatient services**25 visits**
per *benefit year*

Chiropractic Services

- Services of a *physician* who is a *non-participating provider***\$25**
for all treatments received during any one day, further
limited to **\$325** (13 visits) for all treatments rendered
during a *benefit year*

Lifetime Maximum

- For all medical benefits.....**\$2,000,000**
during your lifetime

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

Benefits will be paid for *covered expense* you incur under this *plan*. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and COE. The maximum *covered expense* for services provided by a *participating provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider*, you will not be responsible for any amount in excess of the *negotiated rate*.

If you go to a *hospital* which is a *participating provider*, you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider*, you should request that all your provider services be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center*. An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Note: If an *other health care provider* is participating in a Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a *participating provider* for the purposes of determining *covered expense*.

Non-Participating Providers. The maximum *covered expense* for services provided by a *non-participating provider* will always be the lesser of the billed charge or the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS, and the definition of "Scheduled Amount" in the DEFINITIONS section. You will be responsible for any billed charge which exceeds the *scheduled amount* for services provided by a *non-participating provider*.

The maximum *covered expense* for *non-participating providers* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Other Health Care Providers. The maximum *covered expense* for services provided by an *other health care provider* will always be the lesser of the billed charge or a *reasonable charge*. You will be responsible for any billed charge which exceed a *reasonable charge* for the services of an *other health care provider*.

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital*, in excess of the approved amount as determined by Medicare; or
2. By a *physician* or *other health care provider*, in excess of the lesser of the maximum *covered expense* stated above, or:
 - a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
 - b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this *plan*.

CO-PAYMENTS MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable Co-Payment, the benefits of this *plan* will be paid up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Co-Payments and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CO-PAYMENTS

If your Co-Payment is a percentage, the *claims administrator* will apply the applicable percentage to the amount of *covered expense*. This will determine the dollar amount of your Co-Payment.

MEDICAL BENEFIT MAXIMUMS

The plan does not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits paid to you on your behalf under any other health plan the *plan administrator* provides.

Prior Plan Maximum Benefits. If you were covered under the *prior plan*, any benefits paid to you under the *prior plan* will reduce any maximum amounts you are eligible for under this *plan* which apply to the same benefit.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in Plan Exclusions and Limitations. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the *provider*. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

SCHEDULES FOR NON-PARTICIPATING PROVIDERS

This section explains how the *claims administrator* determines the *scheduled amount* (the maximum amount considered *covered expense* for *non-participating providers*) and is, subject to the maximums, conditions, exclusions and limitations of this *plan*.

SERVICE AREAS

A provider's *service area* is determined by the area in which the provider's principal place of business is located.

- **Service Area 1:** Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.
- **Service Area 2:** Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.
- **Service Area 3:** Counties of Marin, San Francisco, San Mateo and Santa Clara.
- **Service Area 4:** Counties of Los Angeles and Riverside (City of Palm Springs only).
- **Service Area 5:** Orange County.
- **Service Area 6:** Counties of Kern, Riverside (except City of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.
- **Service Area 7:** San Diego County.
- **Service Area 8:** Counties of Fresno, San Joaquin, Sonoma and Stanislaus.
- **Service Area 9:** Imperial County.
- **Service Area 10:** Outside California.

Important Note: The *claims administrator* has the right to adjust, without notice, all schedules found in this section in order to maintain the relationship between these *scheduled amounts* for *non-participating providers* and the fee schedule negotiated by the *claims administrator* with *participating providers*. Benefits are determined based on the schedule in effect at the time the claim is paid.

CHARGES BY A PHYSICIAN WHO IS A NON-PARTICIPATING PROVIDER

1. Charges for services of a *physician* who is a *non-participating provider* are determined by multiplying the "Unit Value" of the service (listed in the Unit Value Schedule) by the appropriate "Unit Allowance" listed in the Unit Allowance Schedule. The "Unit Allowance" varies according to the *service area* of the provider.
2. For any procedure not listed in the Unit Value Schedule, the *plan* provides a benefit on the basis of comparable service.
3. The Unit Value Schedule listed in this *plan description* is only a partial listing.

For services provided by a *physician* who is a *non-participating provider*, *covered expense* will not exceed the amount determined by the following process. First, the *claims administrator* determines the appropriate "Unit Allowance" for the service by determining in which *service area* the *physician* performed the service. Then the "Unit Value" of that service is multiplied by the appropriate "Unit Allowance". The resulting amount is the maximum amount of *covered expense* paid for that service under the *plan*.

The *claims administrator* has developed a Unit Value Schedule for covered services. An excerpt of this Schedule is set forth in this section. Notice that for each service listed in the Schedule, there is a "Procedure Code" and a "Unit Value". *Physicians* use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Medical Association and are widely used throughout the medical profession.

Your *physician* should be able to identify for you which "Procedure Code(s)" applies to the service(s) to be performed. Remember, the maximum allowable *covered expense* may be less than the *physician's* charge for such services. You are responsible for paying any amount by which this charge exceeds the maximum allowable *covered expense*, in addition to any Co-Payment required under this *plan*.

If you want assistance in determining the maximum allowable *covered expense* for services provided by a *physician* who is a *non-participating provider*, you may telephone the *claims administrator* at the number shown on your identification card.

Remember, if you obtain your health care services from a *participating provider*, you will be able to determine the amount of your financial responsibility more simply. *Participating providers* have agreed not to charge any more for their services than the *negotiated rate*, leaving you only the amount of your Co-Payment described in the SUMMARY OF BENEFITS.

UNIT ALLOWANCE SCHEDULE

Service Area	Surgery	Anesthesia	Medicine	Radiology	Pathology
1	\$110.00	\$25.00	\$4.80	\$9.50	\$1.05
2	110.00	25.00	4.80	9.50	1.05
3	120.00	26.00	5.10	10.50	1.15
4	120.00	26.00	5.10	10.50	1.15
5	120.00	26.00	5.10	10.50	1.15
6	110.00	25.00	4.80	9.50	1.05
7	110.00	25.00	4.80	9.50	1.05
8	110.00	25.00	4.80	9.50	1.05
9	110.00	25.00	4.80	9.50	1.05
10	186.00	47.00	8.00	16.00	2.00

**UNIT VALUE SCHEDULE
(Partial Listing)**

PROC CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE	BASIC ANESTHESIA
Skin			
10060	Incision and drainage of abscess	0.45	3.0
11100	Biopsy of skin, including closure	0.40	3.0
11770	Excision of pilonidal cyst or sinus	1.66	4.0
Breast			
19120	Excision of breast tumor, unilateral	2.82	3.0
19200	Radical mastectomy, including pectoral muscles and axillary nodes	8.99	4.0
Fractures			
21315	Nasal, simple, closed reduction	1.02	4.0
25565	Closed radial and ulnar shafts, manipulative reduction	3.60	3.0
27232	Femur and neck, manipulative reduction, including traction	6.30	3.0
Heart			
33400	Aortic valvuloplasty, with bypass	16.00	15.0
33420	Valvotomy, mitral valve, closed	14.55	15.0
Throat			
42650	Dilation, salivary duct	0.34	4.0
42820	Tonsillectomy and adenoidectomy, under 12 years	2.88	4.0
Digestive			
43620	Total gastrectomy	13.38	7.0
44950	Appendectomy	4.04	7.1
47600	Cholecystectomy	6.90	6.0
Rectum			
46200	Fissurectomy	2.36	3.0
46250	Hemorrhoidectomy, external, complete	2.58	3.0
Male			
55801	Prostatectomy, perineal (sub-total)	10.31	6.0

Female			
58180	Supracervical (sub-total) hysterectomy with or without tubes or ovaries	7.08	6.0
Maternity			
59510	Cesarean section, including antepartum and postpartum care	12.50	7.2
Thyroid			
60200	Local excision of cyst of thyroid	5.37	5.0
60240	Thyroidectomy, total or complete	9.53	6.0
Ear			
69420	Myringotomy	0.58	4.0
69501	Transmastoid antrotomy	6.40	5.0

SURGERY (two or more surgical procedures). When two or more surgical procedures are performed during the same operative session, the following Unit Values apply unless otherwise stated in this Schedule:

Major procedure	100% of the Unit Value
Second procedure	50% of the Unit Value
Third procedure	25% of the Unit Value
Fourth procedure	25% of the Unit Value
Fifth procedure	25% of the Unit Value

SURGERY (assistant surgeon). The Unit Value for the services of an assistant surgeon is **20%** of the unit value for the primary surgeon.

ANESTHESIA (anesthesiologist or anesthetist). The total Unit Value for the services of an anesthesiologist or anesthetist is the basic anesthesia value for that procedure and a Unit Value for the actual time spent administering anesthesia.

MEDICINE	UNIT VALUE
99205 Office Visit -- initial comprehensive exam.....	18.00
99212 Office Visit -- problem-focused examination evaluation, and/or treatment	4.31
99351 Home Visit -- problem-focused examination, evaluation, and/or treatment, same illness	7.67
99231 Hospital Visit -- problem-focused examination, evaluation, and/or treatment, same illness	6.49
99241 Consultation -- problem-focused examination and/or evaluation	10.00

RADIOLOGY

Diagnostic

70210	Sinuses and paranasal, limited.....	3.00
70250	Skull, limited.....	3.36
74241	Upper gastrointestinal tract.....	8.64
74415	Nephrotomography	9.74

Therapeutic

77261	Therapeutic radiology treatment planning, simple.....	7.00
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Nuclear Medicine

78000	Thyroid uptake	4.00
79000	Hyperthyroidism, initial evaluation	18.14

PATHOLOGY

81000	Urinalysis, routine, complete.....	3.51
85031	Hematology, manual complete	11.00
87081	Microbiology - culture, bacterial screening	10.00

CHARGES BY A HOSPITAL WHICH IS A NON-PARTICIPATING PROVIDER

1. The maximum charge considered *covered expense* for outpatient care provided by a *hospital* which is a *non-participating provider* is the *reasonable charge*.
2. The maximum charge considered *covered expense* for inpatient care provided by a *hospital* which is a *non-participating provider* is shown in the schedule below. The amount varies by the *service area* of the *hospital*.

INPATIENT HOSPITAL SCHEDULE

Service Area	Mental or Nervous Disorders and Substance Abuse	All Other Conditions
1	\$250 per day	\$ 540 per day
2	250 per day	540 per day
3	270 per day	540 per day
4	270 per day	580 per day
5	270 per day	540 per day
6	250 per day	540 per day
7	250 per day	540 per day
8	250 per day	540 per day
9	250 per day	540 per day
10	450 per day	1,000 per day

NOTE: *Covered expense* for *mental or nervous disorders* and *substance abuse* services provided by a *non-contracting psychiatric health facility* is further limited to **60%** of the amounts listed in the above table. Actual benefit payments as stated elsewhere in the *plan description* for those services will be applied to the additionally limited amounts.

CHARGES BY A DAY TREATMENT CENTER WHICH IS A NON-PARTICIPATING PROVIDER

The maximum charge considered *covered expense* for outpatient care provided by a *day treatment center* which is NOT part of, or affiliated with, a *hospital* which is a *participating provider* is shown in the schedule below. The amount varies by the *service area* of the *day treatment center*.

DAY TREATMENT CENTER SCHEDULE

Service Area

1.....	\$ 250 per day
2.....	250 per day
3.....	270 per day
4.....	270 per day
5.....	270 per day
6.....	250 per day
7.....	250 per day
8.....	250 per day
9.....	250 per day
10.....	450 per day

NOTE: Actual benefit payments as stated elsewhere in the *plan description* for those services will be applied to the additionally limited amounts.

CHARGES BY AN AMBULATORY SURGICAL CENTER WHICH IS A NON-PARTICIPATING PROVIDER

The maximum charge considered *covered expense* for outpatient surgery provided by an *ambulatory surgical center* which is a *non-participating provider* is shown in the schedule below. The amount varies by the *service area* of the center.

AMBULATORY SURGICAL CENTER SCHEDULE

Service Area	Each Session
1.....	\$ 540
2.....	540
3.....	540
4.....	580
5.....	540
6.....	540
7.....	540
8.....	540
9.....	540
10.....	1,000

CHARGES BY OTHER SPECIFIC PROVIDERS WHICH ARE NON-PARTICIPATING PROVIDERS

The maximum charge considered *covered expense* for services and supplies provided by the following providers which are *non-participating providers* is the lesser of the billed charge or the *reasonable charge*.

NON-PARTICIPATING PROVIDER EXCEPTIONS

Under certain exceptions, the *claims administrator* makes exceptions to the amount of payment for *covered expense* incurred for the services of a *non-participating provider*. These exceptions are:

- *Emergency services* provided by other than a *hospital*;
- The first 48 hours of *emergency services* provided by a *hospital* (this exception will continue beyond the first 48 hours if, in the *claims administrator's* judgment, you cannot be safely moved);
- An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* (see MEDICAL MANAGEMENT: AUTHORIZATION PROGRAM for details); or
- Charges of a *physician* who has a specialty which is not represented in the Prudent Buyer Plan network.

For these exceptions, *covered expense* for the services of a *non-participating provider* is the lesser of the billed charge or the amount shown below.

Type of Provider	Maximum Covered Expense is ..
Physicians.....	the Customary and Reasonable Charge
All Other Non-Participating Providers	a Reasonable Charge

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under Plan Exclusions and Limitations, benefits will be provided for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate with the *hospital*, or unless your *physician* orders, and the *plan* authorizes, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.
4. Routine radiology and laboratory exams received within seven days prior to a scheduled surgery. The exams must be provided and billed by the *hospital* where the surgery is to take place.

Covered expense includes take home drugs dispensed by the *hospital's* pharmacy at the time you are discharged from the *hospital*.

Emergency room care must be for the first treatment of a medical *emergency* and emergency room care for an accidental injury must be received within 72 hours of the injury date.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*, for up to 100 days per *benefit year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Home Health Care. The following services provided by a *home health agency* or *visiting nurse association*:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by the *home health*.

In no event will benefits exceed 100 visits during a *benefit year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Hospice Care. The *plan* will pay up to 100 days during your lifetime for:

1. Outpatient *hospice* care.
2. Services of a registered nurse, licensed practical nurse and licensed vocational nurse.
3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
4. Medical social services.
5. Services of a home health aide.
6. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
7. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*.
8. Medical supplies. Oxygen and related respiratory therapy supplies.
9. Bereavement counseling for your family,
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

You must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified by your *physician* and submitted to the *claims administrator*.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to the *claims administrator* every 30 days.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

The maximum payment will not exceed **\$600** for the services or supplies received during any one day when provided by a *home infusion therapy provider* which is not a *participating provider*.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. See MEDICAL MANAGEMENT: AUTHORIZATION PROGRAM.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities,

illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.
- (2) Emergency services or transportation services provided by a licensed ambulance company for ground service that is provided to you as a result of a "911" emergency response system* request for assistance if you have an *emergency* medical condition requiring ambulance transport.
2. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
3. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an *emergency* medical condition that requires ambulance transport services, please call the "911" emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic radiology and laboratory services. Certain imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. Other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes; and
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. The *claims administrator* will determine whether the item satisfies the conditions above.

Pediatric Asthma Equipment and Supplies. The following items when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing.
2. Inhaler spacers and peak flow meters.

These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S.) treating an *accidental injury* to natural teeth which occurs while you are covered under the *plan*. Services must be received during the six months following the date of injury. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Pregnancy and Maternity Care (Employee & Spouse Only)

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.
2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is an *employee* or enrolled *spouse*.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The organ or tissue recipient; or
2. The organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not an enrolled *beneficiary* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining our prior authorization, or which are provided at a facility other than a transplant center approved by the *claims administrator*. See MEDICAL MANAGEMENT: AUTHORIZATION PROGRAM for details.

Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the treatment of *mental or nervous disorders* or *substance abuse*, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services for treatment of *mental or nervous disorders* and *substance abuse* as stated in the "Hospital" provision of MEDICAL CARE THAT IS COVERED. Benefits for *mental or nervous disorders* are limited to 30 days per *benefit year*.

If you are in the *hospital* on December 31 of any *year*, you have the right to any unused benefit days of that *year* for the rest of that *hospital stay*. However, benefit days of the next *year* cannot be used for that same *hospital stay*.

2. Outpatient visits to a *day treatment center* for treatment of *mental or nervous disorders*.
3. *Physician's* visits during a covered *stay* or for outpatient psychotherapy or psychological testing, limited to a maximum payment of **\$50** each visit to a *physician* who is a *participating provider* and **\$25** each visit to *physician* who is a *non-participating provider*.

All inpatient and outpatient *physician's* visits are limited to one visit per day.

All inpatient services covered under this provision must be those which are regularly provided and billed by a *hospital*.

Treatment for *substance abuse* does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

Routine Physical Exam (Subscriber & Spouse Only)

1. Services and supplies provided in connection with a routine test to detect cervical cancer (*i.e.*, pap smear).
2. *Physician's* services for routine physical examinations.
3. Radiology and laboratory services in connection with routine physical examinations.

This *plan* will pay up to a maximum benefit of **\$250** per *benefit year*.

Preventive Care (Dependent Children Only)

1. *Physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services in connection with routine physical examinations.

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*.

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer (*i.e.*, pap smear).

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs does not include the costs associated with any of the following:

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Outpatient Manipulation Therapy

Services of a *physician* for outpatient manipulation therapy or conjunctive therapy for treatment of a covered illness, injury or condition. The treatment plan must offer a reasonable expectation of significant improvement.

Chiropractic Services.

Services of a Chiropractor is covered if *medically necessary* and approved by the Chiropractic network.

For the services of a *non-participating provider* only, our maximum payment is limited to **\$25** for all treatments during any one day and not more than **\$325** (13 visits) for all treatments during each *benefit year*.

Physical Therapy, Physical Medicine and Occupational Therapy.

The following services provided by a *physician* under a treatment plan which offers a reasonable expectation of significant improvement:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.

Up to a combined maximum of 25 visits in a year for all covered services are payable. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

If approved by the Claims Administrator prior to treatment, benefits for up to 12 additional visits in a Plan Year are provided when treatment follows post-neurological surgery, orthopedic surgery, cerebral vascular accident, third degree burns, head trauma or spinal cord injury.

Such additional visits are not payable if prior authorization is not obtained. (See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM.)

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:
 - a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
 - b. Insulin pumps.
 - c. Pen delivery systems for insulin administration (non-disposable).
 - d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.
 - e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

2. Diabetes education program which:
 - a. Is designed to teach a *beneficiary* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *beneficiary* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.

Diabetes education services are covered under *plan* benefits for professional services by *physicians*, up to one visit per lifetime.

3. The following items are covered under your *prescription drug* benefits:
 - a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.
 - b. Insulin syringes, disposable pen delivery systems for insulin administration.
 - c. Testing strips, lancets, and alcohol swabs.

These items must be obtained either from a retail *pharmacy* or through the mail service program (see YOUR PRESCRIPTION DRUG BENEFITS).

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a *pharmacy* and are covered under your *plan's prescription drug* benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a *pharmacy* are covered as medical supplies under your *plan's* medical benefits.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

PLAN EXCLUSIONS AND LIMITATIONS

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

Crime or Nuclear Energy. Conditions caused by an act of war. Conditions caused by release of nuclear energy, whether or not the result of war.

Not Covered. Services received before your *effective date* or during an inpatient *stay* that began on or before your *effective date*. Services received after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Excess Amounts. Any amounts in excess of *covered expense* or the Lifetime Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to the right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *member* and a provider, for which reimbursement under the *Medicare* program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Chronic or rehabilitative therapy for delays in development, including: hyperkinetic syndromes, attention deficit disorders, learning disabilities, behavior problems, mental retardation or autistic disease of childhood. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental or Nervous Disorders or Substance Abuse" provision of MEDICAL CARE THAT IS COVERED.

Services for conditions attributable to chemical dependency or to a Mental Disorder, except as specifically stated in "Mental or Nervous Disorders or Substance Abuse" provision of MEDICAL CARE THAT IS COVERED.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, visiting nurse association, or home infusion therapy provider* as specifically stated in the "Home Health Care", or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of morbid obesity as determined by the Claims Administrator if:

- a. Surgical treatment of the obesity is necessary to treat another life threatening condition involving obesity, and
- b. It has been documented that non-surgical treatments of the obesity have failed.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, sterilization reversal, in vitro fertilization and gamete intrafallopian transfer. Infertility is (1) the presence of a condition recognized by a Physician as the cause of infertility, or (2) the inability to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care*, rest cures, or treatment of chronic pain, except as specifically provided under the "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services, or nutritional counseling, except as specifically provided or arranged by the *plan administrator*, or as stated under the Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Food supplements.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Cervical Cancer Screening", " Breast Cancer ", "Prostate Cancer Screening", or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PREVENTIVE CARE BENEFITS.

Acupuncture. Acupuncture treatment. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin or medications dispensed in a *physician's* office or at an urgent care facility, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, dietary supplements, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Bulimia. Inpatient services for bulimia and/or bulimia nervosa (binge-purge syndrome).

Smoking Cessation. Services for smoking cessation or reduction, nicotine use of addiction, caffeine addiction.

Gambling. Services of pathological gambling or codependency.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

Pregnancy. Pregnancy or maternity care for dependent children.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

No payment will be made under this *plan* for expenses incurred for or in connection with any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. However, the benefits of this *plan* will be provided subject to the following:

1. The *plan administrator* will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.
2. You must advise the *claims administrator* in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the *claims administrator* may require to facilitate enforcement of the *plan administrator's* rights. You must not take action which may prejudice the *plan administrator's* rights or interest under the *plan*. Failure to give the *claims administrator* such notice or to cooperate with the *claims administrator*, or actions that prejudice the *plan administrator's* rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing the *plan administrator*.
3. The *plan administrator* will be entitled to collect its lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

PRESCRIPTION DRUG PROGRAM

YOUR PRESCRIPTION DRUG BENEFITS - Benefits are provided by PAID PRESCRIPTION/MERCK-MEDCO, Call Customer Service at 1-800-711-0917, for details.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each *member*, per *benefit year*, and are largely determined by California law. Any coverage you have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this Definitions provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the plan would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as an employee pays before a plan which covers you as a dependent. But if you are eligible for Medicare, and Medicare pays (a) after the plan which covers you as a dependent, but (b) before the plan which covers you as an employee, then the plan which covers you as a dependent pays before the plan which covers you as an employee.

For example: You are covered as a retired employee under this plan and Medicare would pay first. You are also covered as a dependent under another plan under which Medicare would pay second. In this situation, the plan which covers you as a retired employee will not pay first; instead, the plan which covers you as a dependent will pay first.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *benefit year* pays before the plan of the parent whose birthday falls later in the *benefit year*. However, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
 - b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employee, provision 6 applies.
 5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as a *subscriber*, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.
 6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

In no event will you be entitled to benefits from this *plan* in excess of those which you would have received if no Other Plan benefits were available.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. The *plan administrator* is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision. Such timely information must include an Explanation of Benefits statement (EOB) from the Other Plan.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and the *plan administrator's* liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, the *plan administrator* has the right to pay that Other Plan any amount the plan administrator determines to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy the plan administrator's liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, the *plan administrator* has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR COVERED PERSONS ELIGIBLE FOR MEDICARE

For Active Employees and Family Members. Any Covered Person who is a full-time employee or a family member of a full-time employee, and eligible for Medicare, will receive the full benefits of this Plan, except for the following:

1. Covered Person who are receiving treatment for end-stage renal disease following the first 30 months such Covered Person are entitled to end-stage renal disease benefits under Medicare; and
2. Covered Person who are entitled to Medicare benefits as disabled persons; unless the Covered Person have a current employment status, as determined by Medicare rules, through a *group* of 100 or more employees (according to OBRA legislation).

For cases where exceptions 1 or 2 apply, we will determine our payment and then subtract the amount of benefits available from Medicare. We will pay the amount that remains after subtracting Medicare's payment. Please note, we will not pay any benefit when Medicare's payment is equal to or more than the amount which we would have paid in the absence of Medicare.

For Retired Employees and Their Spouses. If you are a retired employee or the spouse of a retired employee and you are eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be reduced.

When you incur covered expense under this Plan, we will determine our payment and then subtract the amount of your benefits available from Medicare Parts A and B. We will pay the amount that remains after subtracting Medicare's benefits.

We will apply this method of payment when you are retired and eligible to enroll in Medicare Part A, whether or not you are actually enrolled in Medicare Parts A or B, and whether or not benefits to which you are entitled are actually paid by Medicare.

For example: Say you are a retired employee, a retired employee's spouse or that exceptions 1 or 2 above for active employees and family members apply to you. Say also that you are billed for **\$100** of covered expense, and in the absence of Medicare we would have paid **\$80**. If Medicare pays **\$50**, we would subtract that amount from the **\$80** and pay **\$30**. The combined amount of benefits from Medicare and this *plan* will equal, but not exceed, what your benefit would have been from this *plan* alone if you were not eligible for Medicare.

UTILIZATION REVIEW PROGRAM

Benefits are provided only for *medically necessary* and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your *dependents*.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by the *claims administrator* and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits".

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions.
- Organ and tissue transplants.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home infusion therapy.
- Admissions to a *skilled nursing facility*.

- Treatment of certain severe mental disorders (schizophrenia, schizoaffective disorder, bipolar disorders, delusional depression or pervasive developmental disorder).
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
 - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
 - Organ and tissue transplants.
 - Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Home infusion therapy.
 - Admissions to a *skilled nursing facility*.
 - Treatment of certain severe mental disorders (schizophrenia, schizoaffective disorder, bipolar disorders, delusional depression or pervasive developmental disorder).
 - Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET

scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when the *claims administrator* is notified while service is ongoing, for example, an *emergency* admission to the *hospital*.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* admission, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Scheduled, non-emergency inpatient *hospital stays*.
 - Authorizations for organ and tissue transplants will be provided only if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - A specified number of additional visits for physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Physical Therapy, Physical Medicine or Occupational Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.

- Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Treatment of certain severe mental disorders (schizophrenia, schizoaffective disorder, bipolar disorders, delusional depression or pervasive developmental disorder).
- Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be paid for those services.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed your benefits will be reduced as shown in the “Effect on Benefits”.

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.
2. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

3. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure. The toll-free number is printed on your identification card.
2. When the *claims administrator* determines that the service is *medically necessary* and appropriate, they will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.
3. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. The *claims administrator* will send written notice to you and your *physician* within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrators* are not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

THE MEDICAL NECESSITY REVIEW PROCESS

The *claims administrator* will work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, the *claims administrator* is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.
4. If the *claims administrator* does not have the information they need, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,
 - reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The *claims administrator*, through a case manager, may recommend an alternative plan of treatment which may include services not covered under this *plan*. The *plan administrator* does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or the *claims administrator's* claims reports. You or your family may also call the *claims administrator*.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. The *claims administrator* anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If the claims administrator determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A case manager will review the

medical records and discuss your treatment with the attending *physician*, you and your family.

The *claims administrators* make treatment recommendations only; any decision regarding treatment belongs to you and your *physician*. The *plan* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward the Lifetime Maximum.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *plan administrator* and *claims administrator* have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *beneficiary*, which alternatives may be offered and the terms of the offer.
3. Any authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *beneficiary*.
4. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *beneficiary*.

Note: The *claims administrator* reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.

3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. The Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

CONDITIONS OF ENROLLMENT

ELIGIBILITY

1. **Employee's Eligibility.** The persons described in the Administrative Services Agreement are eligible to enroll as Employees.
2. **Dependents.** The following are eligible to enroll as dependents:
 - (a) Either the Employee's Spouse or Registered Domestic Partner; and
 - (b) An unmarried Child.

Definition of Dependent

1. **Spouse** is the Employee's Spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is in active service in the armed forces.
2. **Registered Domestic partner** is an individual who has filed, along with the Employee, a Declaration of Domestic Partnership with the State of California, or similar declaration issued by another state, and at the time of enrollment in the plan meet all the following requirements.
 - a. Both persons have a common residence.

- b. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved or adjudged a nullity.
- c. The two persons are not related by blood in a way that would prevent them from being married to each other in the state.
- d. Both persons are at least 18 years of age
- e. Both persons are either (i) members of the same sex or (ii) one or both of the persons are 62 years or older and are entitled for Medicare or Social Security.

Note. If a full-time eligible employee's spouse or domestic partner works and is entitled to health and welfare coverage through his/her employment at no cost or at a minimal cost (less than \$100 per month), the spouse or domestic partner must take at least the minimal medical plan that is offered. The requirement only applies to the spouse or domestic partner and not to dependent children. If a working spouse or domestic partner does not take the coverage offered by his/her employer, the Butte Schools Self-Funded Benefit Programs' Medical Plan will estimate the other group's plan benefits to be 80% of covered expenses incurred (after \$250 deductible), the Butte Schools Self-Funded Programs' Medical Plan will only pay 20% of the bills submitted for payment.

- 3. **Child** is the Employee's, Spouse's or Registered Domestic Partner's unmarried natural child, stepchild, or legally adopted child, subject to the following:
 - a. The child depends on the Employee, Spouse or Registered Domestic Partner for financial support or the Employee, Spouse or Registered Domestic Partner is legally required to provide group health coverage for the child pursuant to an administrative or court order. A Child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
 - b. The unmarried child is under 19 years of age, or if over the age of 19, that child is eligible until his or her 25th birthday, provided he or she qualifies as a dependent for federal income tax purposes. The Claims Administrator must receive this information in writing. An overage dependent who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

- c. Unmarried Children enrolled before age 25 who, upon reaching age 25, depend on the Employee, Spouse or Registered Domestic Partner for support and are unable to work due to mental retardation or physical handicap. A Physician must certify this disability in writing. This certification must be received by the Claims Administrator within 31 days of the Child's 25th birthday. After the Child's 27th birthday, the Claims Administrator may request proof of continuing dependency and disability, but not more often than yearly.
- d. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the Employee, Spouse or Registered Domestic Partner have either: (a) the right to control the health care of the Child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the Child's adoption.

Legal evidence to control the health care of the Child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the Child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the Employee's, the Spouse's or the Registered Domestic Partner the right to control the health care of the child.

Exception. A foster child is not covered unless we receive a legal evidence of the intent to adopt issued by the court and the Employee, Spouse or Registered Domestic Partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Eligibility Date ("waiting" period)

1. An Employee's eligibility date is shown on the Employee's identification card.
2. A Dependent become eligible for coverage on the later of: (a) the date the Employee becomes eligible for coverage; or (b) the date such person qualifies as a Dependent under the Plan.

Exceptions to the Waiting Period

1. If, after having completed the waiting period, if any, the Employee ceases to be eligible due to termination of employment, and returns to an eligible status within six months after the date employment terminated, that person will become eligible on the first day of the month following the date of return. This exception does not apply for persons who become eligible on their date of hire.
2. If an eligible person was covered under the Prior Plan, the time spent under the Prior Plan will be used to satisfy, or partially satisfy, that person's waiting period, if any, under this Plan.

ENROLLMENT

To enroll as an Employee, or to enroll Dependents, the Employee must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the Plan Administrator within 31 days from your eligibility date. The Plan Administrator must receive this application within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for Employees, on your eligibility date; and (b) for Dependents, on the later of (i) the date the Employee's coverage begins, or (ii) the first day of the month after the Dependent becomes eligible. If you become eligible before the Plan takes effect, coverage begins on the effective date of the Plan, provided the enrollment application is on time and in order.
2. **Late Enrollment:** If you file an enrollment application or membership change form with the Plan Administrator more than 31 days after your eligibility date, you must wait until the next Open Enrollment Period to enroll.
3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this Plan, you will be eligible to reapply for coverage on the first day of the month coinciding with or following 12 months from the date you applied for coverage. You will not be required to wait 12 months to enroll if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn, Newly-Adopted Children and Children for Whom the Employee is Legal Guardian. If the Employee (Spouse or Registered Domestic Partner, if the Spouse or Registered Domestic Partner is enrolled) is already covered:(1) any child born to the Employee, Spouse or Registered Domestic Partner will be covered from the moment of birth; and (2) any Child being adopted by the Employee, Spouse or Registered Domestic Partner will be covered from the date on which either: (a) the adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the Employee, Spouse or Registered Domestic Partner the right to control the health care of the Child (in the absence of a written document, other evidence of the Employee's, Spouse's or Registered Domestic Partner's right to control the health care of the child may be used); or (b) the Employee, Spouse or Registered Domestic Partner assumed a legal obligation for full or partial financial responsibility for the Child in anticipation of the child's adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form and (3) any Child for whom the Employee, Spouse or Registered Domestic Partner is the legal guardian will be covered on the date of the court decree.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the Employee must enroll the Child within the 31-day period by submitting a membership change form to the Plan Administrator.

Special Enrollment Periods

You may enroll without waiting for the next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA continuation.
 - b. You certified in writing at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan.
 - c. You have lost coverage under the other health plan wherein you were covered as an individual or dependent, or your coverage under a COBRA continuation was exhausted.
 - d. You properly file an application with the Plan Administrator within 31 days from the date on which you lose coverage.
2. A court has ordered coverage be provided for a Spouse or dependent Child under your employee health plan and application is filed within 31 days from the date the court order is issued.
3. The Claims Administrator does not have a written statement from us stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following 12 months from the date you applied for coverage.

4. You have a change in family status through either marriage or the birth or adoption of a Child. You may also enroll a new Spouse or Child at that time. You must enroll within 31 days of the marriage, birth, or adoption. Coverage will become effective as follows:
 - a. If you are enrolling following marriage, the first day of the month following the date you filed the enrollment application.
 - b. If you are enrolling following the birth or adoption of a Child, as of the date of birth or adoption.

Your Spouse (if you are already married), who is eligible but not enrolled, may also enroll at the time of the birth or adoption of a Child. Application must be made within 31 days of the birth or date of adoption; coverage will be effective on the first day of the month following the date the application is filed.

Transferring From Another Group-Sponsored Plan. Individuals may transfer coverage from another Group-sponsored plan only in accordance with application procedures stated above.

CANCELLATION OF COVERAGE

No written notice is sent to the Covered Person when coverage is cancelled. A Covered Person's coverage is cancelled under the following conditions:

EMPLOYEE

1. On the date the Plan is cancelled, or
2. On the next due date for the required monthly contribution after the Employee no longer meets the eligibility requirements established by the Plan Administrator, or
3. At the end of the period for which required monthly contributions have been paid when the required monthly contributions for the next period are not paid, or
4. On the next due date for the required monthly contribution after the Claims Administrator receives written notice of the Employee's voluntary cancellation of coverage.

If the required monthly contributions are paid, coverage may continue for an Employee who is granted a temporary leave of absence up to six months, a sabbatical year's leave of absence of up to 12 months, or an extended leave of absence due to illness certified annually by the Plan Administrator.

The Employee may be entitled to continue coverage according to other provisions of this Plan.

SPOUSE

1. On the date the Employee's coverage is cancelled (except in the event of the Employee's death, when the Spouse may elect coverage under **CONTINUATION OF COVERAGE** and **COVERAGE FOR RETIRED CERTIFICATED EMPLOYEES AND SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES**), or
2. On the next due date for the required monthly contribution after final decree of divorce, annulment or dissolution of marriage (unless the Spouse elects **CONTINUATION OF COVERAGE**), or

3. At the end of the period for which required monthly contributions have been paid when the required monthly contribution for the next period are not paid.

The Spouse may be entitled to continue coverage according to other provisions of this Plan.

CHILD

1. On the date the Employee's coverage is cancelled (except in the event of the Employee's death, when the Child may be eligible for **CONTINUATION OF COVERAGE**), or
2. On the next due date for the required monthly contributions after the Child age 19 or over no longer qualifies as a dependent for federal income tax purposes or reaches age 25 (unless the Child elects **CONTINUATION OF COVERAGE**), or
3. On the next due date for the required monthly contributions after marriage (unless the Child elects **CONTINUATION OF COVERAGE**), or
4. At the end of the period for which required monthly contributions have been paid when the required monthly contributions for the next period are not paid.

A Child may be entitled to continue coverage according to other provisions of this Plan.

Note: If a domestic partnership terminates, the Employee must notify the Claims Administrator, by providing a signed, notarized copy of the Affidavit of Termination of Domestic Partnership within 30 days of the termination. A new Registered Domestic Partner may not be enrolled under this *plan*, until at least six months after the Affidavit of Termination has been filed.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *plan* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your *plan administrator* for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either an *employee* or *dependent*; and (b) a *child* who is born to or placed for adoption with the *employee* during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the *plan*. The events will be referred to throughout this section by number.

1. For Employees and Dependents:

- a. The *employee's* termination of employment, for any reason other than gross misconduct; or
- b. A reduction in the *employee's* work hours.

2. For Retired Employees and their Dependents. Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *plan's* filing for Chapter 11 bankruptcy, provided that:

- a. The *plan* expressly includes coverage for retirees; and

- b. Such cancellation or reduction of benefits occurs within one year before or after the *plan's* filing for bankruptcy.

3. **For Dependents:**

- a. The death of the *employee*;
- b. The *spouse's* divorce or legal separation from the *employee*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *plan*; or
- d. The *employee's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

An *employee* or *dependent*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *plan* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. We will notify either the *employee* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *plan administrator* will notify the *employee* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a *dependent* will be notified of the COBRA continuation right.
3. You must inform the *plan administrator* within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The *plan administrator* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *plan administrator* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *beneficiaries* within a family, or only for selected *beneficiaries*.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Cost of Coverage. You may be required to pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *plan administrator* each month during the COBRA continuation period.

Besides applying to the *employee*, the *employee's* rate also applies to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*;
2. A *child* if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of *children* enrolled); and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, an *employee* or *dependent*, who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *employee's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan*, the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the required monthly contribution is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *dependents* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *employee*, divorce or legal separation, or the end of dependent *child* status;
3. The end of 36 months from the date the *employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *employee* will end 36 months from the date the *employee* became entitled to Medicare;
4. The date the *plan* terminates;
5. The end of the period for which required monthly contributions are last paid;
6. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date, following the election of COBRA, the *beneficiary* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

Subject to the *plan* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *dependents* may continue coverage for 36 months after the *employee's* death. But coverage could terminate prior to such time for either the *employee* or *dependent* in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this *plan* ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The *plan administrator* will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *beneficiaries* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *beneficiary* must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The *beneficiary* must furnish the *plan administrator* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Cost of Coverage. For the 19th through 29th months that the total disability continues, the cost for the extended continuation coverage must be remitted to us. This cost (called the "required monthly contribution") shall be subject to the following conditions:

1. If the disabled *beneficiary* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *beneficiary* remains covered, depending upon the number of covered dependents. If the disabled *beneficiary* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us each month during the period of extended continuation coverage. We must receive timely payment of the required monthly contribution in order to maintain the extended continuation coverage in force.

3. You may be required to pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The required monthly contribution shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *beneficiary* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *beneficiary* is not covered following the 18th month.

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;
3. The date the *plan* terminates;
4. The end of the period for which required monthly contributions are last paid;
5. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date, following the election of COBRA, the *beneficiary* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *plan administrator* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

SENIOR COBRA CONTINUATION FOR QUALIFYING BENEFICIARIES

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of required monthly contributions as stated in the *plan*, coverage under this *plan* may be continued for the *employee*, the *employee's spouse*, and the *employee's former spouse* (if any) under Section 10116.5 of the

Insurance Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272).

For the purposes of this section, “former *spouse*” means: (a) an individual who is divorced from the *employee*; or (b) an individual who was married to the *employee* at the time of the *employee*’s death.

Requirements. The *employee* and *spouse* may continue coverage under this *plan* if:

1. The *employee*, or the *employee* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to continue coverage under COBRA, as described in the preceding section;
2. The *employee* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *employee* has worked for the employer for at least the prior five years; and
4. The *employee* is at least 60 years old on the date employment ended.

The former *spouse* may continue coverage under this *plan* in accordance with this section if he or she was covered as a qualified beneficiary under COBRA, as described in the preceding section.

Notice and Election. The *plan administrator* will notify the *employee* or *spouse* and the former *spouse* of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA is scheduled to end.

For the *employee* and *spouse*, this continuation may be chosen for both, for the *employee* only, or for the *spouse* only. The former *spouse* may elect this continuation for himself or herself only.

To elect this continuation, you must notify the *plan administrator* in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect this continuation.

Cost of Coverage. This continuation is subject to payment of required monthly contribution to the employer at the time it is due. The *plan administrator* may require that you pay the entire cost of your continuation coverage. The *plan administrator* is responsible for the timely payment of the required monthly contribution due for the

continuation of your coverage under the *plan*. The rate for continuation coverage under this section shall be 213% of the applicable group rate. For the purpose of determining the required monthly contribution payable, the *spouse* or former spouse continuing coverage alone will be considered to be an *employee*.

When Continuation Ends. This continuation will end on the earliest of:

1. The end of the period for which the required monthly contributions are last paid;
2. The date the *plan* terminates;
3. The date, following the election of Senior COBRA, the *employee*, *spouse*, or former *spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the *employee*, *spouse*, or former *spouse* first becomes entitled to Medicare;
5. The date the *employee*, *spouse*, or former *spouse* reaches age 65;
or
6. For the *spouse* or former *spouse*, five years from the date the *spouse's* or former *spouse's* COBRA continuation coverage ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage. If your continuation under this *plan* ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

CONTINUATION FOR DISABLED DISTRICT EMPLOYEES

If an Employee who is a district employee becomes disabled as a result of a violent act sustained while performing duties in the scope of his or her employment, the Employee's benefits under the Plan may be continued.

Employee's Eligibility. The Employee must be a member of the State Teachers' Retirement System or a classified school employee member of the Public Employees' retirement System and be covered under the Plan at the time of the violent act causing the disability.

Cost of Coverage. The Plan Administrator may require that the Employee pay the entire cost of continuation coverage. This cost -- called the required monthly contribution charge -- must be remitted to the Plan Administrator each month for the duration of the continuation coverage. The Claims Administrator must receive payment of the required monthly contribution charge each month from the Plan Administrator in order to maintain the coverage in force. The Claims Administrator will accept required monthly contribution charges only from the Plan Administrator, and payment by the Employee directly to the Claims Administrator will not continue coverage.

When Continuation Coverage Begins. When continuation coverage is elected and the required monthly contribution charge is paid, coverage is reinstated back to the date the Employee became disabled, so that no break in coverage occurs, but only if the Employee elects to continue coverage within sixty (60) days after coverage terminates. For Dependents acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions stated in this Plan Description.

When Continuation Coverage Ends. This continuation coverage ends for the Employee on the earliest of:

1. The date the Plan terminates, or
2. The end of the period for which the required monthly contribution charges were last paid, or
3. The date the maximum benefits of the Plan are paid.

For Dependents, this continuation coverage ends according to the provisions stated under **CANCELLATION OF COVERAGE**.

COVERAGE FOR RETIRED CERTIFICATED EMPLOYEES AND SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES

1. A certificated employee who retires under any public retirement system may be eligible to enroll as an Employee under the Plan.
2. After the death of the Employee, coverage may continue for a Spouse enrolled through a Participating Employer listed in the Administrative Services Agreement until one of the following occurs:
 - a. The Spouse becomes enrolled under another group health plan, or
 - b. The Spouse's coverage cancels as described under **CANCELLATION OF COVERAGE** due to reasons other than the Employee's death.

Covered Persons must contact their Participating Employer to determine whether this coverage is available.

COVERAGE DURING A LABOR DISPUTE

If eligible Employees stop working because of a labor dispute, the Plan Administrator may arrange for coverage to continue as follows:

1. The required monthly contributions are determined by the Claims Administrator. These required monthly contributions become effective on the due date for required monthly contributions after work stops.
2. The Plan Administrator is responsible for collecting the required monthly contributions from those Employees who choose to continue coverage. The Plan Administrator is also responsible for submitting those contributions to the Claims Administrator on or before each due date.
3. The Claims Administrator must receive contributions for at least 75% of the Employees who stop work because of the labor dispute. If at any time participation falls below 75%, coverage may be cancelled. This cancellation is effective ten days after written notice to the Plan Administrator. The Plan Administrator is responsible for notifying the Employees.
4. Coverage during a labor dispute may continue up to six months. After six months, coverage is cancelled automatically without notice to Covered Persons.

EXTENSION OF BENEFITS

If you are a *totally disabled employee* or a *totally disabled dependent* and under the treatment of a *physician* on the date of discontinuance of the *plan* your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered *totally disabled* as long as the inpatient stay is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, the *claims administrator* must receive proof of your continuing total disability at least once every 90 days while benefits are extended.
2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. The *claims administrator* must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, the *claims administrator* must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
 - a. You are no longer *totally disabled*.
 - b. The maximum benefits available to you under this *plan* are paid.
 - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
 - d. A period of 12 months has passed since your extension began.

CONVERSION AND HIPAA COVERAGE

If your coverage for medical benefits under this *plan* ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. Conversion coverage and HIPAA coverage are available upon request if you meet the requirements stated below. Both conversion and HIPAA coverage are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your employer's *plan*.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us within 31 days of the date your coverage under the employer's *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the *agreement* between the *group* and us terminates and is replaced by another group plan within 60 days.
2. You are not eligible if your coverage under this *plan* ends because subscription charges are not paid when due because you (or the *subscriber* who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

Important: The intention of conversion coverage is not to replace the coverage you have under this *plan*, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group *plan* ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, or a similar state program including Senior-COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *plan* ends. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

When coverage under your employer's group *plan* ends, you will receive more information about how to apply for conversion or HIPAA coverage, including a postcard for requesting an application and a telephone number to call if you have any questions. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

GENERAL PROVISIONS

Summary Plan Description. (*plan description*) This *plan description* is not a *participation agreement*. It does not change the coverage under the *participation agreement* in any way. This *plan description*, which is evidence of coverage under the *participation agreement*, is subject to all of the terms and conditions of that Agreement.

Providing of Care. The *plan administrator* is not responsible for providing any type of *hospital*, medical or similar care, nor is the *plan administrator* responsible for the quality of any such care received.

Independent Contractors. The relationship between *plan administrator* and the providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not agents of *plan administrator* nor is the *plan administrator* or any of the *plan administrator's* employees, an employee or agent of any *hospital*, medical group or medical care provider of any type. The *plan administrator* is not liable for any claim or demand for damages connected with any injury resulting from any treatment.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Blue Cross and/or Blue Shield Providers. When you obtain covered health care services, the amount you pay, if it is not a flat dollar amount, is usually calculated on the lower of the:

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

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating *covered person* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *covered person* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with BC Life. If you have any questions or complaints about the BlueCard Program, please call us at the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan*, both the *participation agreement* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *plan* is subject to amendment, modification or termination according to the provisions of the *participation agreement* and the Declaration of Trust establishing the Butte Schools Self-Funded Programs without your consent or concurrence.

Protection of Coverage. The *plan administrator* does not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the *plan*.

Free Choice of Provider. This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A

participating *physician* may, after notice from us, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. When an inpatient stay is necessary, services are limited to those which could not have been performed before admission.

Expense in Excess of Benefits. The *plan administrator* is not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to the *claims administrator* within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the *plan* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. The benefits of this *plan* will be paid directly to *participating providers* and medical transportation providers. Also, we will pay other providers of service directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, we will pay the benefits of this *plan* to that party. These payments will fulfill our obligation to you for those covered services.

Exception: Under certain circumstances we will pay the benefits of this *plan* directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide us the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;

2. If the *insured employee* does not reside with the patient, either a copy of the judicial order requiring the *insured employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;
3. If the *insured employee* does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the *insured employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order;
4. The name and address of the person to be reimbursed, the name and policy number of the *insured employee*, the name of the patient, and other necessary information related to the coverage.

Right of Recovery. When the amount paid exceeds the *plan administrator's* liability under this *plan*, the *plan administrator* has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Workers' Compensation Insurance. The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. Your *participating employer* may require that you contribute all or part of the costs of these required monthly contributions. Please consult your *participating employer* for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* or *other health care provider* any amounts the plan owes to that provider (not including co-payments, if any), even in the unlikely event that the *plan administrator* fails to pay that provider. You may be liable, however, to pay *non-participating providers* any amounts not paid to them by the *plan administrator*.

Area of Service. The benefits of this *plan* are provided for covered services received anywhere in the world.

Confidentiality and Release of Medical Information.

We will use reasonable efforts, and take the same care to preserve the confidentiality of the *beneficiary's* medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the

beneficiary. Medical information may be released only with the written consent of the *beneficiary* or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. *Beneficiaries* may access their own medical records.

We may release your medical information to professional peer review organizations and to the *plan administrator* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *plan administrator* to conduct the review or audit.

Medical Policy and Technology Assessment.

Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of *Claims Administrator's* medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including *Claims Administrator's* medical directors, physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

Financial Arrangements with Providers. *Claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its *members* and *beneficiaries* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* or an affiliate is a party, including all persons covered under the *plan*.

Under the above-referenced contracts between Providers and *claims administrator* or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *plan* may differ from the rates paid for persons covered by other types of products or programs offered by *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that *claims administrator* or its affiliates offer several types of products and programs. The *members*, *beneficiaries* and *claims administrator* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

Also, under arrangements with some Providers certain discounts, payments, rebates settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by *claims administrator* or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by *claims administrator* or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by *claims administrator* or an affiliate in determining its fees or subscription charges or premiums.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract is terminated by a Blue Cross or Blue Shield plan (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the Blue Cross or Blue Shield plan prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the Blue Cross or Blue Shield plan prior to termination. If the provider does not agree with these contractual terms and conditions, the provider's services will not be continued beyond the contract termination date.

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-

case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider's services will not be continued. If you disagree with the determination regarding continuity of care, you may file a complaint as described in the COMPLAINT NOTICE.

CLAIMS REVIEW

The benefits of this *plan* are provided only for those services that are considered *medically necessary* and satisfy all other terms and conditions of this *plan*. The fact that a *physician* prescribes or orders a service does not, in itself, mean that the service is *medically necessary* or that the service is *covered expense*. Consult this *plan description* or telephone the *claims administrator* at the number shown on your identification card if you have any questions, regarding whether services are covered.

The *claims administrator* has responsibility for determining whether services are *medically necessary*. That determination will be made during claims review, unless reviews for medical necessity already were conducted for those services that are subject to the provisions stated under MEDICAL MANAGEMENT PROGRAM.

When the claim is submitted for benefit payment, it is reviewed against guidelines, established by the *claims administrator* for medical necessity, beginning with preliminary screening against general guidelines designed to identify *medically necessary* services. If there is a question as to the medical necessity of the services, the claim will be further reviewed against more detailed guidelines. If the medical necessity still cannot be clearly determined, the claim will be reviewed by a *physician* advisor for a final determination.

Action on a *member's* claim, including denial and reasons for denial, will be provided by the *claims administrator* to the *member* in writing.

Reconsiderations

If you or your *physician* disagree with an initial claims review determination, or questions how it was reached, reconsideration may be requested. The request may be made by you, your *physician* or someone chosen to represent you.

Appeals

If the reconsidered decision is not satisfactory, a request for an appeal on the reconsidered decision may be submitted in writing to the *claims administrator*. The request may be made by you, your *physician* or someone chosen to represent you.

In the event that the appeal decision still is unsatisfactory, the remedy is binding arbitration, which is explained in the next section of this *plan description*.

How to Initiate Requests for Reconsideration or Appeals

Requests for reconsideration of claim denials or appeals of reconsidered determinations must be directed to the *claims administrator* at the following address:

**BC Life & Health Insurance Company
P. O. Box 1210
Rancho Cordova, CA 95741-1210**

Requests must be made as follows:

1. In writing, and
2. Within 60 days of receiving the original denial when the request is for reconsideration, or
3. Within 30 days of receiving the reconsidered determination when the request is for an appeal.

Requests must include the following:

1. Any medical information that supports the medical necessity of the services for which payment was denied, and any other information you or your *physician* feels should be considered, and
2. A copy of the original denial.

The *claims administrator* must respond to the request for reconsideration or appeal within 60 days of receiving the request, except when the *claims administrator* indicates before the 60th day that additional time is required to review the request. In that event, the *claims administrator* is permitted a total of 120 days in which to respond to the request.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The *beneficiary* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *beneficiary* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *beneficiary* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *beneficiary*.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the *beneficiary* making written demand on the *plan administrator*. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *beneficiary* and the *plan administrator*, or by order of the court, if the *beneficiary* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the beneficiary and the *plan administrator*.

DEFINITIONS

The meanings of key terms used in this *plan description* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this *plan description*, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, are referred to a *non-participating provider*, but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*, and
3. The referral has been authorized by the *claims administrator* before services are rendered.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to BC Life & Health Insurance Company. On behalf of BC Life & Health Insurance Company, Blue Cross of California shall perform all administrative services in connection with the processing of claims under the *plan*.

Cosmetic Surgery is performed to reshape normal structures of the body and is intended solely to improve the appearance of the individual.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the *pre-existing condition* exclusion period under this *plan* and/or to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan*).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by *the claims administrator*, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Day treatment center is an outpatient psychiatric facility which is part of or affiliated with a *contracting hospital*. It must be licensed according to state and local laws to provide outpatient care and treatment of *mental or nervous disorders* or *substance abuse* under the supervision of *physicians*.

Dependent meets the *plan's* eligibility requirements for family members as outlined under CONDITIONS OF ENROLLMENT.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *beneficiary* reasonably perceives could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care for the acute phase of a *mental or nervous disorder*, “hospital” also includes *psychiatric health facilities*.

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically necessary services or supplies are those that the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

- c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Mental or nervous disorders are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Some mental or nervous disorders are: schizophrenia, manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; adjustment reactions; reactions to stress; anorexia nervosa and bulimia.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be; but medical conditions that are caused by your behavior that may be associated with these mental conditions (e.g., self-inflicted injuries) are not subject to these limitations. One or more of these conditions may be specifically excluded in this *plan*.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Non-participating provider is a *hospital* or *physician* NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A facility which provides diagnostic radiology services;
3. A blood bank;
4. A durable medical equipment outlet;
5. A clinical laboratory;
6. *A skilled nursing facility;*
7. *A home health agency;*
8. A licensed ambulance company;
9. *A hospice;*
10. *An ambulatory surgical center;*
11. *A home infusion therapy provider;* or
12. A licensed birth center.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is a *hospital or physician* participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. *Participating providers* agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this *plan description*, and when benefits would be payable if the services were provided by a physician as defined above:
 - a. A dentist (D.D.S.)
 - b. An optometrist (O.D.)
 - c. A dispensing optician
 - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. A licensed clinical psychologist
 - f. A chiropractor (D.C.)
 - g. A clinical social worker (L.C.S.W.)*
 - h. A marriage and family therapist (M.F.T.)

- i. A physical therapist (P.T. or R.P.T.)*
- j. A speech pathologist*
- k. An audiologist*
- l. An occupational therapist (O.T.R.)*
- m. A respiratory care practitioner (R.C.P.)*
- n. A *psychiatric mental health nurse* (R.N.)*
- o. A licensed midwife
- p. A nurse midwife**
- q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

Plan is the set of benefits described in this *plan description* and in the amendments to this *plan description*, if any. These benefits are subject to the terms and conditions of the *plan*. If changes are made to the plan, an amendment or revised *plan description* will be issued to each *subscriber* affected by the change.

Plan Administrator refers to BUTTE SCHOOLS SELF-FUNDED PROGRAMS.

Plan Description refers to this written description of the benefits provided under the Plan.

Prior plan is a plan sponsored by us which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with the *claims administrator* will be subject to the *non-contracting hospital* penalty in effect at the time of service.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reasonable charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Registered Domestic partner meets the *plan's* eligibility requirements for Registered Domestic Partners as outlined under CONDITIONS OF ENROLLMENT.

Retired employee is a former full-time employee who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

Review center functions as a contact point with the *claims administrator* for the *member*. The review center answers questions and facilitates provisions of this *plan* under MEDICAL MANAGEMENT PROGRAM.

Scheduled amount is determined according to the SCHEDULES FOR NON-PARTICIPATING PROVIDERS. Any amount by which a *non-participating provider's* charge exceeds this schedule will not be considered *covered expense*. **You are responsible for paying any such excess amount.**

Service area is the area in which the provider's principal place of business is located. The counties encompassed by each service area are listed in the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.

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

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Subscriber is the primary covered individual; that is, the person who is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*.

Substance abuse means those conditions, not including those covered as *mental or nervous disorders*. These conditions include, but are not limited to: (1) psychoactive substance abuse induced *mental or nervous disorders*; (2) psychoactive substance abuse dependence; and (3) psychoactive substance use abuse. Substance abuse does not include addiction to, or dependency on, tobacco or food substances (or dependency on items not ingested).

Totally disabled subscribers are *subscribers* who, because of illness or injury, are unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Totally disabled family members are *family members* who are unable to perform all activities usual for persons of that age.

Totally disabled retired employees are *retired employees* who are unable to perform all activities usual for persons of that age.

Year or **benefit year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *subscriber* and *family members* who are enrolled for benefits under this *plan*.