



**Medical Plan Document
And Disclosure Form**

ProtectPlus 15

**Group Insurance Trust
of the
California Society of
Certified Public Accountants**

January 1, 2011

Grandfathered Plan Disclosure

The Group Insurance Trust of California Society of CPA's believes that the benefits provided under this plan by the employer constitute a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Under this plan you are entitled to the benefit of certain protections of the Affordable Care Act that apply by law only to non-grandfathered plans. However, certain requirements of the Affordable Care Act such as non-discrimination rules do not apply to your employer because of a grandfathered health plan status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a change from grandfathered health plan status can be directed to the plan administrator at Board of Trustees Group Insurance Trust of the California Society of CPA's 1800 Gateway Drive, Suite 201 San Mateo, CA 94404. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Dear Plan Beneficiary:

This *Medical Plan Document and Disclosure Form* provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Plan participants 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 words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this *Medical Plan Document and Disclosure Form* carefully so that you understand all the benefits your *plan* offers. Keep this *Medical Plan Document and Disclosure Form* 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 Anthem Blue Cross Life & Health Insurance Company, P.O. Box 60007, Los Angeles, CA 90060 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:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY

TABLE OF CONTENTS

TYPES OF PROVIDERS	3
SUMMARY OF BENEFITS.....	5
MEDICAL BENEFITS	6
DEDUCTIBLES	6
CO-INSURANCE/CO-PAYMENTS	7
MEDICAL BENEFIT MAXIMUMS	9
PRESCRIPTION DRUG BENEFITS.....	13
PRESCRIPTION BRAND NAME DRUG DEDUCTIBLE.....	13
YOUR MEDICAL BENEFITS.....	15
HOW COVERED EXPENSE IS DETERMINED	15
DEDUCTIBLES, CO-INSURANCE/CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS.....	16
CO-INSURANCE/CO-PAYMENTS	16
OUT-OF-POCKET AMOUNTS	17
BENEFIT MAXIMUMS	17
CONDITIONS OF COVERAGE	18
MEDICAL CARE THAT IS COVERED.....	19
MEDICAL CARE THAT IS NOT COVERED	34
PRE-EXISTING CONDITION EXCLUSION.....	39
REIMBURSEMENT FOR ACTS OF THIRD PARTIES.....	39
YOUR PRESCRIPTION DRUG BENEFITS	41
PRESCRIPTION DRUG MAXIMUM ALLOWED AMOUNT.....	41
PRESCRIPTION DRUG DEDUCTIBLE AND CO-PAYMENTS	41
HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS.....	42
PRESCRIPTION DRUG UTILIZATION REVIEW	43
PRESCRIPTION DRUG CONDITIONS OF SERVICE	43
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED.....	44
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED.....	44
COORDINATION OF BENEFITS.....	47
DEFINITIONS	47
EFFECT ON BENEFITS	47
ORDER OF BENEFITS DETERMINATION	48
OUR RIGHTS UNDER THIS PROVISION.....	49
BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES.....	50
MEDICAL MANAGEMENT PROGRAMS.....	51

UTILIZATION REVIEW PROGRAM.....	51
UTILIZATION REVIEW REQUIREMENTS.....	51
EFFECT ON BENEFITS	52
HOW TO OBTAIN UTILIZATION REVIEWS	52
AUTHORIZATION PROGRAM.....	53
SERVICES REQUIRING AUTHORIZATION	54
EFFECT ON BENEFITS	54
WHEN AUTHORIZATION WILL BE PROVIDED.....	55
HOW TO OBTAIN AN AUTHORIZATION.....	57
THE MEDICAL NECESSITY REVIEW PROCESS	58
PERSONAL CASE MANAGEMENT.....	59
HOW PERSONAL CASE MANAGEMENT WORKS	59
EFFECT ON BENEFITS	60
QUALITY ASSURANCE	61
HOW COVERAGE BEGINS AND ENDS.....	62
HOW COVERAGE BEGINS.....	62
ELIGIBLE STATUS	62
ELIGIBILITY DATE.....	63
EFFECTIVE DATE	64
SPECIAL RULES APPLICABLE TO EMPLOYERS.....	68
WITH NO EMPLOYEES (GROUPS OF ONE).....	68
HOW COVERAGE ENDS.....	69
CONTINUATION OF COVERAGE.....	70
DEFINITIONS	70
ELIGIBILITY FOR COBRA CONTINUATION	70
TERMS OF COBRA CONTINUATION.....	71
EXTENSION OF CONTINUATION DURING TOTAL DISABILITY	73
CONTINUATION OF COVERAGE (CALCOBRA).....	75
ELIGIBILITY FOR CALCOBRA CONTINUATION	75
TERMS OF CALCOBRA CONTINUATION	76
EXTENSION OF BENEFITS.....	78
POST-COBRA AND -CALCOBRA CONTINUATION FOR QUALIFYING MEMBERS	79
EXTENSION OF CONTINUATION DURING TOTAL DISABILITY.....	81
HIPAA COVERAGE	82
ELIGIBILITY OF SURVIVING FAMILY MEMBERS TO ELECT CONTINUATION COVERAGE.....	83
GENERAL PROVISIONS.....	84
REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.....	87

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE

SERVICE 89

DEFINITIONS..... 90

GENERAL PLAN INFORMATION 106

FOR YOUR INFORMATION 121

ORGAN DONATION 121

NOTICE 122

CLAIM FIDUCIARY..... 122

LIST OF PARTICIPATING PROVIDERS 122

STATEMENT OF ERISA RIGHTS 123

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION..... 125

GROUP INSURANCE TRUST OF THE CALIFORNIA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS

The Group Insurance Trust of the California Society of Certified Public Accountants (“*trust*”) assures the *plan participant* and his or her *dependents*, during the continuance of this *plan*, that all benefits hereinafter described shall be paid to them in the event that they incur *covered expense*. The *plan* is subject to the terms, provisions and conditions recited on the following pages.

Although the *trust* expects and intends to continue the *plan* indefinitely, the *trust* reserves the right to amend and terminate the *plan* at any time and for any reason. If the *plan* is amended or terminated, *plan participants* and his or her *dependents* may not receive benefits as described in this section. However, they may be entitled to receive different benefits, or benefits under different conditions. In no event will a *plan participant* or his or her *dependents* become entitled to any vested rights under the *plan*.

The *trust* has caused this *Medical Plan Document and Disclosure Form* to take effect as of 12:01 a.m. Pacific Standard Time on January 1, 2011, at San Mateo, California.

This *Medical Plan Document and Disclosure Form* and the benefits described herein supersede any and all previous plan documents and/or amendments thereto. The benefits described will be effective for all claims incurred on or after the above date.

The *plan administrator* shall have full and exclusive authority to determine all questions of eligibility and coverage and full authority to construe the provisions of *the Medical Plan Document and Disclosure Form* and the *plan*.

COVERAGES AND BENEFITS PROVIDED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT

The California Society of Certified Public Accountants sponsors a variety of benefits for member firms and their *plan participants* and families. The benefits and coverages described herein are provided through a *trust*, established and sponsored by the California Society of Certified Public Accountants. The *trust*, the Group Insurance Trust of the California Society of Certified Public Accountants, is a self-funded multiple employer welfare (MEWA) arrangement as defined under the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1002(40)(A). This is not an insurance contract and the *plan* and *trust* are not acting as or deemed to be an insurance company.

TYPES OF PROVIDERS

Please read the following information so you will know from whom or what group of providers health care may be obtained. If you have special health care needs, you should carefully read those sections that apply to those needs. The meanings of words and phrases in italics are described in the section of this booklet entitled DEFINITIONS.

Participating Providers. The *plan* has made available to the *beneficiaries* a network of various types of “Participating Providers.” These providers are called “participating” because they have agreed to participate in the *claims administrator’s* preferred provider organization program (PPO). They have agreed to provide our *beneficiaries* with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of “Participating Providers” in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We will provide you with a directory of *participating providers* upon request.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in the *plan* network. They have not agreed to the *negotiated rates* and other provisions of the *plan* contract.

Contracting Hospitals. Another type of provider is the “Contracting Hospital.” This is different from a *hospital* which is a *participating provider*. The *claims administrator* has contracted with most hospitals in California to obtain certain advantages for patients covered under the *plan*. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over **90%**--accept.

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* will cover expense you incur from them when they are practicing within their specialty the same as if the care were provided by a medical doctor.

Other Health Care Providers. “Other Health Care Providers” are neither *physicians* nor *hospitals*. They are mostly free-standing 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 *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* and that you or your *dependents* 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 the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Participating and Non-Participating Pharmacies. “Participating Pharmacies” agree to charge only the *negotiated drug fee* to fill the *prescription*. You pay only your *co-payment* amount. “Non-Participating Pharmacies” have not agreed to the *negotiated drug fee*. The amount that will be covered as *prescription drug maximum allowed amount* is significantly lower than what these providers customarily charge.

Centers of Expertise Transplant Facilities. The *claims administrator* has established a *center of expertise (COE)* network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). These “*COE*” agree to accept the *COE negotiated rate* as payment in full for covered services. A *participating provider* in the *plan* network is not necessarily a *centers of expertise* transplant facility. Organ transplants which are provided at a facility other than a *COE* will be paid on a *non-participating provider* benefit level.

Bariatric Facilities. Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. These providers agree to accept the *COE negotiated rate* as payment in full for covered services. A *participating provider* in the *plan* network is not necessarily a *centers of expertise* bariatric facility. Bariatric procedures which are provided at a facility other than a *COE* will be paid on a *non-participating provider* benefit level.

SUMMARY OF BENEFITS

The benefits of this *plan* are provided only for those services that are considered to be *medically necessary* as defined in the *Medical Plan Document and Disclosure Form*. 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 booklet 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 booklet, 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 *Medical Plan Document and Disclosure Form* 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 <i>plan</i> are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
--

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles.*

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

* Applies to mental and nervous as well as medical benefits.

** The Family Aggregate Deductible is met when the total deductible amounts satisfied by all family members exceed two times the individual deductible amount.

Additional Deductibles.

- Emergency Room Deductible\$100
- Non-Certification Deductible.....\$250*

* In addition, if certification is not obtained, the amount of your covered benefit will be reduced by **40%**.

Exceptions. In certain circumstances, one or more of these *deductibles* may not apply, as described below:

1. The Calendar Year Deductible will not apply to *participating provider preventive care* and *non-participating provider preventive care*.
2. The Calendar Year Deductible will not apply to the first six (6) office visits (includes visits to outpatient mental health providers), and will not apply to office visits constituting *participating provider preventive care*.
3. The Calendar Year Deductible will not apply to diabetes education program services provided by a *physician* who is a *participating provider*.
4. The Calendar Year Deductible will not apply to bariatric and transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.
5. The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following *emergency* room treatment.
6. The Non-Certification Deductible will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider*. See MEDICAL MANAGEMENT PROGRAM: UTILIZATION REVIEW PROGRAM.

CO-INSURANCE/CO-PAYMENTS

Co-Insurance. After you have met your Calendar Year Deductible, and any other applicable *deductible*, you will be responsible for the following percentages of *covered expense* you incur:

- *Participating Providers* (for medical and for mental and nervous conditions and substance abuse)..... **20%**
- *Other Health Care Providers*..... **20%**
- *Non-Participating Providers* (for medical and for mental and nervous conditions and substance abuse)..... **50%**

Note. In addition to the *co-insurance* shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or a *non-participating provider*. The *plan* pays up to \$540 per day at a *non-participating hospital*.

Exceptions.

1. There will be no *co-payment* for *participating provider preventive care*.
2. Your *co-insurance* for *non-participating providers* will be the same as for *participating providers* for the following services. You will be responsible for charges which exceed the *negotiated rate*.
 - 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-insurance* 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); or
 - d. Charges by a type of *physician* not represented in the *plan* network (for example, an audiologist).
 - e. Cancer Clinical Trials.
3. Office visits, to a *physician* who is a *participating provider*, will be paid at **100%** of *covered expense* for medical, for mental and nervous disorders, or for substance abuse, after you have made a **\$15** *co-payment*.

This exception applies only to the charge for the office visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc. However, there is no *co-payment* or *co-insurance* applied to charges for *participating provider preventive care*, which may include office visits.

4. 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*.
5. Your *co-payment* for services provided by a *participating provider* under Physical Therapy, Physical Medicine, Occupational Therapy, Speech Therapy, Chiropractic Care and Acupuncture will be **\$15**. This *co-payment* will not apply toward satisfaction of any *deductible*, nor will it apply toward satisfaction of the *out-of-pocket amount*.
6. Your *co-insurance* for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) and bariatric procedures authorized by the *claims administrator* and performed at a designated *COE* will be the same as for *participating providers*. Organ transplants and bariatric procedures which are provided at a facility other than a *COE* will be paid at the *non-participating provider* benefit level. See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM.
7. No *co-insurance* will be required for the travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM.

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

- *Participating providers and other health care providers***\$3,000***
per beneficiary
* Subject to aggregate limit of \$6,000 per family.
- *Non-participating providers***\$10,000****
per beneficiary
** No aggregate limit.

Exceptions.

1. Your *co-payment* for office visits to a *physician* who is a *participating provider* 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 visits even after you have reached that amount.
2. Your *co-payment* for diabetes education program services provided by a *physician* who is a *participating provider* 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 services even after you have reached that amount.
3. Expense 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:

Ambulatory Surgical Center.

- For all covered services and supplies when provided by a *non-participating provider*.....**\$350**
per visit

Acupuncture.

- For all covered services when provided by a *participating provider***\$60***
per visit
- For all covered services when provided by a *non-participating provider*.....**\$25***
per visit

* Maximum of 12 visits combined (*participating and non-participating provider*) per calendar year

Bariatric Travel Expense.

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
 - For transportation to the *COE*..... up to **\$130**
per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
 - For transportation to the *COE*..... up to **\$130**
per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
 - Hotel accommodations up to **\$100**
per day, for up to 2 days per trip,
limited to one room,
double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)
 - Hotel accommodations up to **\$100**
per day, for up to 4 days,
limited to one room,
double occupancy
 - For other reasonable expenses (excluding, tobacco, alcohol and drug expenses) up to **\$25**
per day, for up to 4 days per trip

Home Health Care.

- For covered home health services**90***
visits per calendar year
* Maximum of \$75 per day when provided by a *non-participating provider*.

Hospital.

- For all covered services and supplies provided by
a *non-participating provider***\$540**
per day

Infertility Treatment.

- For all covered services and supplies**\$2,000**
per calendar year

Lifetime Maximum.

- For all benefits**\$2,000,000**
per calendar year and
unlimited during your lifetime

Non-Participating Provider Preventive Care.

- Routine Physical Examination (*Beneficiaries Age 7 and Over*):
For all covered services and supplies**1**
visit per year
For all covered services and supplies when
provided by a *non-participating provider***\$250**
per calendar year; the *plan* pays 50%
of the *negotiated rate* for *non-participating*
providers up to \$250 maximum
- Well Baby and Well Child Care:
For all covered services and supplies Consistent with the Guidelines for Health
Supervision of Children and Youth as adopted by the American
Academy of Pediatrics in May, 1982
- Well Woman Care:
For all covered services and supplies**1**
visit per year

**Physical Therapy, Physical Medicine, Occupational Therapy, Chiropractic Care and Speech
Therapy.**

- For covered outpatient services**25**
visits combined (*participating* and

non-participating provider) per calendar year

- For each covered visit when provided by a *non-participating provider* **\$40**
per visit

Skilled Nursing Facility.

- For covered *skilled nursing facility* care when provided by a *participating provider* **100**
days combined (*participating* and *non-participating provider*) per calendar year
- For covered *skilled nursing facility* care when provided by a *non-participating provider* **\$540**
per day; for up to 100 days combined (*participating* and *non-participating provider*) per calendar year

Transplant Travel Expense.

- For the recipient and one companion per transplant episode (limited to six (6) trips per episode)
 - For transportation to the *COE* **\$250**
per trip for each person for round trip coach airfare
 - For hotel accommodations **\$100**
per day, for up to 21 days per trip, limited to one room, double occupancy
 - For expenses such as meals **\$25**
per day for each person, for up to 21 days per trip
- For the donor per transplant episode (limited to one trip per episode)
 - For transportation to the *COE* **\$250**
for round trip coach airfare
 - For hotel accommodations **\$100**
per day, for up to seven (7) days
 - For expenses such as meals **\$25**
per day, up to seven (7) days

Important Note About Mental & Nervous and Substance Abuse Prior Authorization Requests

The Trust has contracted with Anthem Blue Cross's network of specialists and facilities to provide members with mental health and substance abuse benefits. *Outpatient treatment* for mental health or substance abuse does not require pre-authorization from Anthem Blue Cross, but for questions regarding outpatient benefits, please call 1-888-209-7847. *Inpatient* mental health or substance abuse services must be pre-authorized in order to be eligible for payment under the plan. If a member needs this type of service, he or she must first call 1-800-274-7767 for authorization.

Please be aware that if a member seeks treatment from a non-network provider, his or her out-of-pocket costs will be substantially higher. Furthermore, claims for treatment from non-network providers are subject to review and may be rejected if they do not meet the Trust's standards for necessity and appropriateness of treatment.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION BRAND NAME DRUG DEDUCTIBLE

Calendar Year Deductible.

- Individual Deductible.....\$150
- Family Deductible.....\$300*

* The Family Aggregate Deductible is met when the total deductible amounts satisfied by all family members exceed two times the individual deductible amount.

PRESCRIPTION DRUG CO-PAYMENTS. The following *co-payments* apply for each *prescription*:

You will be required to pay your *co-payment* amount to the *participating pharmacy* at the time your prescription is filled.

Participating Pharmacies.

- *Generic Drugs*.....\$10
- *Brand Name Drugs (excluding Self-administered Injectables)*:
 - Formulary.....\$25
 - Non-Formulary.....\$45
- *Self-administered Injectable Drugs (excluding insulin)*
.....**30% of prescription drug maximum allowed amount**

Non-Participating Pharmacies.*

- *Generic Drugs*
\$15 plus 50% of the remaining prescription drug maximum allowed amount plus costs in excess of the prescription drug maximum allowed amount
- *Brand Name Drugs (excluding Self-administered Injectables)*:
 - Formulary:
\$25 plus 50% of the remaining prescription drug maximum allowed amount plus costs in excess of the prescription drug maximum allowed amount
 - Non-Formulary:
\$45 plus 50% of the remaining prescription drug maximum allowed amount plus costs in excess of the prescription drug maximum allowed amount
- *Self-administered Injectable Drugs (excluding insulin)*.....**Not covered**

***Important Note About Prescription Drug Covered Expense and Your Co-Payment**
Prescription drug maximum allowed amount for non-participating pharmacies is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a non-participating pharmacy.

Mail Service Prescriptions.

- *Generic Drugs*.....**\$10**
- *Brand Name Drugs (excluding Self-administered Injectables):*
 - *Formulary*.....**\$25**
 - *Non-Formulary*.....**\$45**
- *Self-administered Injectable Drugs (excluding insulin)*
.....**30% of prescription drug maximum allowed amount**

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

The *plan* will pay for *covered expense* you incur. 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* or *COE* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* and *COE* 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 receive an authorized, specified organ transplant at a *COE*, you will not be responsible for any amount in excess of the *COE negotiated rate* for the covered services of a *COE*. If you choose not to use a *COE*, you will have a greater out-of-pocket expense.

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.

Non-Participating Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* are subject to the *negotiated rate*. Use of *non-participating providers* will result in significantly higher *out-of-pocket amounts*.

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*.

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*.

DEDUCTIBLES, CO-INSURANCE/CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable deductible and your *co-insurance/co-payments*, benefits will be paid up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Insurance/Co-Payments, Out-of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from any other *deductible*. Only charges that are considered *covered expense* will apply toward satisfaction of any *deductible*.

Calendar Year Deductible. Each *year*, you will be responsible for satisfying the *beneficiary's* Calendar Year Deductible before the *plan* begins to pay benefits.

Individual Deductible. The Individual Deductible applies if your coverage covers only the plan participant.

Family Deductible. The Family Deductible is an aggregate deductible applicable to the Family as a whole.

Additional Deductibles.

1. Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital inpatient* from the emergency room immediately following *emergency* room treatment.
2. Each time you are admitted to a *hospital* or have outpatient surgery at an *ambulatory surgical center* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission or procedure if the *claims administrator* is notified of the admission within one day of the admission. Certification is explained in MEDICAL MANAGEMENT PROGRAMS: UTILIZATION REVIEW PROGRAM.

CO-INSURANCE/CO-PAYMENTS

After you have satisfied any applicable deductible, your *co-insurance/co-payments* will be subtracted from the amount of *covered expense* remaining.

If your *co-insurance* is a percentage, the applicable percentage will be applied to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your *co-insurance*.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay *co-insurance* equal to your *out-of-pocket amount* per *beneficiary* during a calendar year, you will no longer be required to pay *co-insurance* for any *covered expense* you incur during the remainder of that *year*.

Participating Providers, COEs and Other Health Care Providers. Only *covered expense* for the services of a *participating provider*, *COE* or *other health care provider* will be counted toward the *participating provider* and *other health care provider out-of-pocket amount*.

After this *out-of-pocket amount* per *beneficiary* has been satisfied during a calendar year, you will no longer be required to pay any *co-insurance* for the covered services provided by a *participating provider*, *COE* or *other health care provider* for the remainder of that *year*.

Non-Participating Providers. Only *covered expense* for the services of a *non-participating provider* will be applied to the *non-participating provider out-of-pocket amount*. After this *out-of-pocket amount* per *beneficiary* has been satisfied during a calendar year, you will no longer be required to pay any *co-insurance* for the covered services provided by a *non-participating provider* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The following *co-payments* will not be applied toward satisfaction of an *out-of-pocket amount*:

1. Charges which are not considered *covered expense*.
2. Office visit to a physician who is a *participating provider*.
3. Routine examinations provided by a *participating provider* under the Well Baby Well Child benefit.
4. *Well woman care* provided by a *participating provider*.
5. *Preventive care* benefits provided by a *participating provider*.
6. Physical Therapy, Physical Medicine, Occupational Therapy, Speech Therapy, Chiropractic Care and Acupuncture provided by a *participating provider*.
7. *Prescription drugs*.

In addition, even after your *out-of-pocket amount* is reached, you will continue to be required to pay your *co-payment* for the above listed items.

BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *beneficiary* in excess of any of the Medical Benefit Maximums. Any amount you incur in excess of the Benefit Maximums is not a *covered expense* or *prescription drug maximum allowed amount*.

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, or for mental or nervous disorders, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED, or for a mental or nervous disorder. 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 MEDICAL CARE THAT IS NOT COVERED. 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, mental or nervous disorder, 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*.
8. The expense must be billed to us within 180 days after the end of the calendar year 2010.
9. An otherwise covered Expense will not be covered if the payee of a check or draft for such expense does not cash the check or draft within 180 days of issuance. This provision will be waived for good cause shown.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefits and Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, the *plan* will provide benefits for the following services and supplies:

Acupuncture. The services of a *physician* for *acupuncture* treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.

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 that are provided to you by a licensed ambulance company as a result of a “911” emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.
3. 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.
4. 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 an emergency response, please call the “911” emergency response system if you are in an area where the system is established and operating.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery. For the services of an *ambulatory surgical center* that is a *non-participating provider*, our maximum payment is limited to **\$350** each time you have outpatient surgery at such *ambulatory surgical center*.

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at an approved *COE* facility. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

You must obtain our prior authorization for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *COE* will be covered at a *non-participating provider* benefit level.**

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.

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 (routine exams are provided under well-woman benefits – see “PARTICIPATING PROVIDER PREVENTIVE CARE” in this section).
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 do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

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.

For payment for *non-participating providers*, the cost will be based on the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Coverage for clinical trials is restricted to *participating providers* in the state of California unless the protocol for the clinical trial is not provided for at a California *hospital* or by a California *physician*.

Chemotherapy.

Christian Science. The following provisions relate only to charges for Christian Science treatment:

1. A Christian Science Sanatorium will be considered a *hospital* for purposes of this booklet. The sanatorium must be accredited by the Department of Care of the First Church of Christ, Scientist; Boston, Massachusetts.
2. The term *physician* includes a Christian Science Practitioner approved and accredited by the Mother Church, The First Church of Christ, Scientist.

Benefits for the following services will be provided when a *beneficiary* manifests symptoms of a covered illness or injury and receives Christian Science treatment for such symptoms.

1. **Christian Science Sanatorium.** Services provided by a Christian Science Sanatorium if the *beneficiary* is admitted for active care of an illness or injury.
2. **Christian Science Practitioner.** Office visits for services of a Christian Science Practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions of the **EXCLUSIONS AND LIMITATIONS** in this booklet apply equally to Christian Science benefits as to all other benefits and providers of care.

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.). *We* 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 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: (i) the *beneficiary* is less than seven years old; (ii) the *beneficiary* is developmentally disabled; or (iii) the *beneficiary'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. 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*.

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 *dependents* 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*.

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).

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

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.

We will determine whether the item satisfies the conditions above.

Hemodialysis Treatment.

Home Health Care. The following services provided by a *home health agency*:

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 agency*.

A visit of eight hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the “Hospice Care” provision of this section.

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: (i) patient or alternative caregiver training; and (ii) 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.

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

Hospice Care. The *plan* will pay during your lifetime for:

1. Room and board charges in an inpatient *hospice* unit.
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 hyper-alimentation.
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.

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 *claims administrator* 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 at an *ambulatory surgical center*.

Infertility Treatment. Diagnosis and treatment of *infertility*, as *medically necessary*, provided you are under the direct care and treatment of a *physician*. Artificial insemination and in vitro fertilization are covered; any *drugs* prescribed for *infertility* and any laboratory procedures related to in vitro fertilization are not covered.

Injectable Drugs for Birth Control. Injectable drugs for birth control administered in a *physician's* office if *medically necessary*.

Jaw Joint Disorders. The *plan* will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints--TMJ), including the complex of muscles, nerves and other tissues related to those joints.

Mental Health and Addiction Equality. Federal law provides that the financial requirements and treatment limitations that apply to mental health benefits or substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. You have the right to request from your plan administrator (or health insurer) information on the criteria used for determining the medical necessity of mental health or substance use disorder benefits. You further have the right to request the reasons for any denial of reimbursement or payment for services relating to those benefits.

Non-Participating Provider Preventive Care Includes the Following:

1. Well Baby and Well Child Care. The following services for a *dependent child* under 7 years of age:
 - A *physician's* services for routine physical examinations.
 - Immunizations given as standard medical practice for children. You will not have to pay a *co-payment* for immunizations provided by a *participating provider*.
 - Radiology and laboratory services in connection with routine physical examinations.
2. Well Woman Care. Benefits are provided for one visit per calendar year for a routine gynecological examination. Benefits for routine gynecological exams include patient history, physical exam, breast exams, breast exam instructions, pelvic exam, mammograms and Cervical

Cancer Screenings if appropriate. Cervical Cancer Screenings consist of services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears, human papillomavirus (HPV) and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*. The calendar year deductible will not apply to these services.

3. Routine Physical Examination. For persons age 7 and over, an annual routine physical examination.

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 the *claims administrator's* prior authorization, or which are provided at a facility other than a transplant center approved by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for details.

You must obtain the *claims administrator's* prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to preoperative tests and postoperative care. See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for details.

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests including colonoscopies and sigmoidoscopies. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

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

Participating Provider Preventive Care Includes the Following:

FOR ADULTS-

1. Abdominal aortic aneurysm one-time screening by ultrasonography for men aged 65-75 who have ever smoked.
2. Alcohol misuse screening and behavioral counseling interventions to reduce alcohol misuse by adults (including pregnant women) in primary care settings.
3. Aspirin use for men age 45-79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage; and

for women age 55-79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase gastrointestinal hemorrhage.

4. Blood pressure screening for high blood pressure in all adults age 18 years and older.
5. Cholesterol screening for:
 - men age 35 years and older for lipid disorders,
 - men age 20-35 years for lipid disorders if they are at an increased risk for coronary heart disease,
 - women aged 20-45 and age 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
6. Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy for adults beginning at age 50 and continuing to age 75.
7. Depression screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up.
8. Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) great than 135/80 mm Hg.
9. Dietary counseling (intensive behavioral) for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
10. Human immunodeficiency virus (HIV) screening by clinicians for all adults at increased risk for HIV infection.
11. Immunization vaccines for the following:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
12. Obesity screening and counseling for all adults, *i.e.*, intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

13. Routine Physical Examination (Beneficiaries Age 7 and Over). For *beneficiaries* age 7 and over for one annual physical examination per year for preventive purposes not related to any actual illness, injury or disease including office visits and diagnostic lab and x-ray expenses. Covered services include the following:
 - A *physician's* services for routine physical examinations.
 - Immunizations given as standard medical practice.
 - Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination.
 - Prostate cancer screenings consisting of services and supplies provided in connection with routine tests to detect prostate cancer.
14. Sexually transmitted infection (STI) prevention counseling, *i.e.*, high intensity behavioral counseling to prevent STIs for adults at increased risk for STIs.
15. Syphilis screening for all adults at increased risk for syphilis.
16. Tobacco use screening, *i.e.*, clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.

For Women, Including Pregnant Women-

1. Anemia screening for iron deficiency anemia on a routine basis for asymptomatic pregnant women.
2. Asymptomatic bacteriuria screening with urine culture at 12-16 weeks' gestation or at the first prenatal visit, if later.
3. BRCA counseling regarding genetic testing/screening for women at higher risk, *i.e.*, women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes must be referred for genetic counseling and evaluation for BRCA testing.
4. Breast cancer mammography screenings for women with or without clinical breast examination, every 1 to 2 years for women aged 40 and older.
5. Breast cancer chemoprevention counseling for women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
6. Breast feeding interventions during pregnancy and after birth to support and promote breast feeding.
7. Cervical cancer screening for women who have been sexually active and have a cervix.
8. Chlamydia infection screening for:
 - all sexually active non-pregnant women aged 24 years and younger,

- all pregnant women aged 24 years and younger and
 - older non-pregnant and pregnant women who are at increased risk
9. Folic Acid supplements for all women planning or capable of pregnancy take a daily supplement containing 0.4 to .8 mg of folic acid.
 10. Gonorrhea screening for all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (*i.e.*, they are young or have other individual or population risk factors).
 11. Hepatitis B virus (HBV) screening for pregnant women at their first prenatal visit.
 12. Osteoporosis screening routinely for women aged 65 and older and for women aged 60 and older at increased risk for osteoporotic fractures.
 13. Rh (D) Incompatibility blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care, and repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
 14. Syphilis screening for all pregnant women for syphilis.
 15. Tobacco use screening and interventions *i.e.*, clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.
 16. Well Woman Care. In general, benefits are provided for one visit per calendar year for a routine gynecological examination. Benefits include the following items 4, 7 listed above.

For Children

1. Alcohol and drug use assessments for adolescents.
2. Autism screening for children at 18 and 24 months.
3. Behavioral/Psychosocial assessments for children of all ages.
4. Cervical dysplasia screening for sexually active females.
5. Congenital hypothyroidism (CH) screening for newborns.
6. Depression screening for adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up.
7. Developmental screening and surveillance for children under age 3, and surveillance throughout childhood.
8. Dyslipidemia screening for children at higher risk of lipid disorders.

9. Fluoride chemoprevention oral supplements at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
10. Gonorrhea preventive medication for the eyes of all newborns, *i.e.*, prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
11. Hearing screening for hearing loss in all newborn infants.
12. Height/length, weight, body mass index, blood pressure and head circumference measurements.
13. Hematocrit or Hemoglobin screening.
14. Hemoglobinopathies screening for sickle cell disease in newborns.
15. Human immunodeficiency virus (HIV) screening by clinicians for all adolescents at increased risk for HIV infection.
16. Immunization vaccines for children from birth to age 18 for the following:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
17. Iron supplements on a routine basis for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.
18. Lead screening for children at risk of exposure.
19. Medical history for all children throughout development.
20. Newborn metabolic/hemoglobin screening.
21. Obesity screening and counseling of children aged 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
22. Oral health risk assessment for young children.

23. Phenylketonuria (PKU) screening for this genetic disorder in newborns.
24. Sexually transmitted infection (STI) prevention counseling, *i.e.*, high intensity behavioral counseling to prevent STIs for sexually active adolescents.
25. Tuberculin testing for children at higher risk of tuberculosis.
26. Visual acuity screening to detect amblyopia, strabismus and defects in visual acuity in children younger than age 5 years.
27. Well Baby and Well Child Care. The following services for a *dependent child* under 7 years of age:
 - A *physician's* services for routine physical examinations.
 - Immunizations listed above as item 16.
 - Radiology and laboratory services in connection with routine physical examinations.
28. An office visit that includes *preventive care* provided by a *participating provider* that (i) is not billed separately or tracked as an individual encounter data separately from the office visit and (ii) is the primary purpose of the office visit constitutes *preventive care*.

With respect to any *preventive care* listed above for which the United States Preventive Services Task Force or the Health Resources and Services Administration guidelines and recommendations do not specify the frequency, method, treatment, or setting of that *preventive care*, the *plan* may use reasonable medical management techniques to determine any coverage limitations. The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention provides information about the recommended age for vaccination, number of doses needed, interval between doses and recommendations associated with particular health conditions with respect to the *preventive care* vaccinations listed above.

Physical Therapy, Physical Medicine and Occupational Therapy (including Chiropractic Care). 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, 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. 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 the *claims administrator* determines that an additional period of *physical therapy, physical medicine or occupational therapy* is both *medically necessary* and likely to result in a significant improvement to your condition by measurably reducing your physical impairment during that period of additional care, the *claims administrator* may authorize a specific number of additional visits.

Note. The limit on visits will not apply to physical therapy or speech therapy treatments received in conjunction with post operative care during the six-month period following orthopedic or other surgery related to the need for physical or speech therapy.

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

Pregnancy and Maternity Care.

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 owner, employee or enrolled *spouse*.

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

Professional Services.

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

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. The *plan* will pay for 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.

4. Cast and molded orthotic devices or individually designed shoes needed by *member* who suffer from foot disfigurement.

Radiation Therapy.

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. Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Skilled Nursing Facility. For *participating providers*, the *plan* will pay inpatient services and supplies provided by a *skilled nursing facility*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. *Skilled nursing facility* services and supplies are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews.

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 for PKU that are not available from a *pharmacy* are covered as medical supplies under your *plan's* medical benefits.

Transplant Travel Expense. The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a *COE*, provided the expenses are authorized by the *claims administrator* (See MEDICAL MANAGEMENT PROGRAM: AUTHORIZATION PROGRAM for details.).

MEDICAL CARE THAT IS NOT COVERED

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.)

Act of War. Conditions caused by an act of war and conditions caused by release of nuclear energy, whether or not the result of war. No individual shall be eligible to participate while in active military service.

Acupuncture. Acupuncture treatment except as specifically stated in the “Acupuncture” provision of MEDICAL CARE THAT IS COVERED. 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.

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

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the “Cancer Clinical Trials” provision under the section MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the “Hospice Care” or “Home Infusion Therapy” provisions of MEDICAL CARE THAT IS COVERED.

Cloning. Cloning of a human being, attempted *cloning*, or any procedure directly or indirectly arising from or related to a *cloning* or attempted *cloning* of a human being or any procedure performed on a *clone* or any service rendered to a *clone*, or any service rendered to a *member* in connection with the effectuation of a Cloning or as a consequence of a Cloning.

Contraceptive Devices. Contraceptive devices prescribed for birth control.

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.

Crime or Nuclear Energy. Conditions that result from: (i) your commission of or attempt to commit a felony, excluding crimes of domestic violence; or (ii) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

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* or rest cures, except as specifically provided under the “Hospice Care” or “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.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, 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” or “Jaw Joint Disorders” provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Education or Counseling. Educational services or nutritional counseling, except as specifically provided or arranged by us, or as stated under the “Diabetes” or “Home Infusion Therapy” provisions of MEDICAL CARE THAT IS COVERED.

Excess Amounts. Any amounts in excess of *covered expense* as defined under Medical Benefit Maximum.

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*.

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

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.

Food or Dietary Supplements. Food or dietary supplements, except as specifically stated under the “Special Food Products” provision of MEDICAL CARE THAT IS COVERED.

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.

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under “Preventive Care (Beneficiaries Age 7 and Over)” benefits of MEDICAL CARE THAT IS COVERED.

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, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer, except as specifically stated under “Infertility Treatment” provision of MEDICAL CARE THAT IS COVERED.

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.

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*.

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

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

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

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

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity, as determined by the *claims administrator*, if the treatment is determined in advance as *medically necessary* and appropriate.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under “Preventive Care (Beneficiaries Age 7 and Over)” provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the “Prosthetic Devices” provision of MEDICAL CARE THAT IS COVERED.

Organ and Tissue Transplants. Organ and tissue transplants, unless preauthorized as provided herein.

Orthodontia. Braces and other orthodontic appliances or services.

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.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice or home infusion therapy provider* as specifically stated in the “Home Health Care,” “Hospice Care,” “Home Infusion Therapy,” or “Physical Therapy, Physical Medicine and Occupational Therapy” provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription *drugs* or medications and insulin, except as specifically stated in the “Home Infusion Therapy” and “Prescription Drug for Abortion” provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

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

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with *urgent care* or an *emergency*.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the “Home Health Care,” “Hospice Care,” “Home Infusion Therapy” or “Physical Therapy, Physical Medicine and Occupational Therapy” provisions of MEDICAL CARE THAT IS COVERED.

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

Private Contracts. Services or supplies provided pursuant to a private contract between the *beneficiary* 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.

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

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 “Preventative Care” provisions of MEDICAL CARE THAT IS COVERED.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the “Home Infusion Therapy” provision of MEDICAL CARE THAT IS COVERED.

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

Sterilization Reversal. Reversal of sterilization.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone, facsimile machine or e-mail.

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.

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 our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

PRE-EXISTING CONDITION EXCLUSION

No Payment will be made for services or supplies for the treatment of a *pre-existing condition* during a period of six months following your *effective date*. The Pre-Existing Condition Exclusion shall not apply to any child under the age of 19 on his or her *effective date*, or to any conditions of pregnancy of the subscriber, spouse or domestic partner. Also, if you were covered under *creditable coverage*, the time spent under the *creditable coverage* will be used to satisfy, or partially satisfy, the six-month period.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *member* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We 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's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.

- If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
- If we paid the provider on a capitated basis, our lien will not be more than 80% of the customary and reasonable charges for those services in the geographic area in which they were given.
- If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
- If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
- If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
- Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

2. You must advise us 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 we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the amount of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG MAXIMUM ALLOWED AMOUNT

Prescription drug maximum allowed amount is the maximum charge for each covered service or supply that will be accepted by the *plan* for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the mail service program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

Prescription drug maximum allowed amount will always be the lesser of the billed charge or the amount shown below. Expense is incurred on the date you receive the *drug* for which the charge is made.

Type of Provider	Prescription Drug Maximum Allowed Amount is
Participating Pharmacies and Mail Service Program	Negotiated Drug Fee
Non-Participating Pharmacies	Drug Limited Fee Schedule

When you choose a *participating pharmacy*, any expense which is not covered under your *prescription drug* benefits will be subtracted. The remainder is the amount of *prescription drug maximum allowed amount* for that claim. You will not be responsible for any amount in excess of the *negotiated drug fee* for the covered services of a *participating pharmacy*.

When the *claims administrator* receives a claim for *drugs* supplied by a *non-participating pharmacy*, any expense which is not covered under your *prescription drug* benefits will be first subtracted, and then any expense exceeding the *drug limited fee schedule*. The remainder is the amount of *prescription drug maximum allowed amount* for that claim.

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

PRESCRIPTION DRUG DEDUCTIBLE AND CO-PAYMENTS

Prescription Drug Calendar Year Deductible. After *prescription drug maximum allowed amount*, is determined, the *claims administrator* will subtract your *prescription drug deductible* from the total amount considered *prescription drug maximum allowed amount*. Each year, you will be responsible for satisfying the individual Calendar Year Deductible before the *plan* begins to pay *prescription drug* benefits.

If two *members* of a family satisfy their Individual Deductible, the Family Deductible will be satisfied. No further deductible will be required for the remainder of that calendar year for any enrolled *member* of that family.

Prescription Drug Co-Payments. After you have met the deductible for the calendar year, the *claims administrator* will subtract your *prescription drug co-payment* for each *prescription* during the remainder of the *year*.

The Prescription Drug Deductible and <i>co-payments</i> are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a *beneficiary* covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled. Provided you have properly identified yourself as a *beneficiary*, a *participating pharmacy* will only charge your *co-payment*.

Many *participating pharmacies* display an “Rx” decal with the *claims administrator’s* logo in their window. For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541.

When You Go to a Non-Participating Pharmacy. If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to the *claims administrator*, at the address below:

Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Forms are also available on line on CalCPA’s website: www.cpaprotectplus.com.

Non-participating pharmacies do not have the necessary prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy’s* portion of the form and sign it.

Claim forms and customer service are available by calling 1-800-700-2541. Mail your claim with the appropriate portion completed by the pharmacist to the *claims administrator* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You are Out of State. If you need to purchase a *prescription drug* out of the state of California, you may locate a *participating pharmacy* by calling 1-800-700-2541. If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to the *claims administrator*. (See “When You Go to a Non-Participating Pharmacy” above.)

When You Order Your Prescription Through the Mail. You can order your *prescription* through the mail service *prescription drug* program. Not all medications are available through the mail service pharmacy.

EXPRESS SCRIPTS NOTE: MAIL PRESCRIPTION BENEFITS ARE ONLY AVAILABLE THROUGH THE EXPRESS SCRIPTS PROGRAM.

The *prescription* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your *co-payment*.

Your first mail service *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent mail service prescriptions, or call the toll-free number. *Co-payments* can be paid by check, money order or credit card.

Order forms can be obtained by contacting Express Scripts, Inc., at 888-613-6091, Monday through Friday, 8:30 a.m. to 8 p.m., ET.

PRESCRIPTION DRUG UTILIZATION REVIEW

Your *prescription drug* benefits include utilization review of *prescription drug* usage for your health and safety. Certain *drugs* may require prior authorization. If there are patterns of over-utilization or misuse of *drugs*, the *claims administrator's* medical consultant will notify your personal *physician* and your pharmacist. The *claims administrator* reserves the right to limit benefits to prevent over-utilization of *drugs*.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the *drug* or medication **must satisfy all** of the following requirements:

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
2. It must be approved for general use by the State of California Department of Health or the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However formulas prescribed by a *physician* for the treatment of phenylketonuria are covered.
4. It must be dispensed from a licensed retail *pharmacy*, or through your mail service program.
5. It must not be used while you are an inpatient in any facility. Also, it must not be dispensed in or administered by an outpatient facility.
6. For a retail *pharmacy*, the *prescription* must not exceed a 30-day supply.
7. *Prescription drugs* federally-classified as Schedule II, which are FDA-approved for the treatment of attention deficit disorder and that require a triplicate prescription form, must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *beneficiary* has to pay double the amount of *co-payment* for retail *pharmacies*. If the *drugs* are obtained through the mail order, the *co-payment* will remain the same as for any other *prescription drug*.

8. For the mail service program, the *prescription* must not exceed a 60-day supply.
9. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.
10. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.
11. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to the *claims administrator* for review.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the *co-payment* for *brand name drugs*.
2. Insulin.
3. Syringes when dispensed for use with insulin and *self-administered injectable drugs* or medications.
4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year* and are subject to the *co-payment* for *brand name drugs*.
5. *Self-administered injectable drugs*.
6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.
7. Diabetic supplies (i.e., test strips and lancets).
8. *Prescription drugs* for treatment of impotence and/or sexual dysfunction *drugs* are limited to organic (non-psychological) causes.
9. The Specialty Pharmacy benefit provides services to members with typically rare and chronic diseases. Specialty Pharmacy dispenses biotech drugs for these conditions, and schedules drug delivery either to the member's home or to a physician's practice. This benefit also provides telephonic therapy management to ensure safety and compliance. This benefit is mandatory for members taking prescriptions included in the Specialty Pharmacy prescription drug list and is subject to the limitations of the Specialty Pharmacy program.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the exclusions and limitations listed under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, *prescription drug* benefits are not provided for or in connection with the following:

1. Immunizing agents, biological sera, blood, blood products or blood plasma.

2. Hypodermic syringes and/or needles except when dispensed for use with insulin and *self-administered injectable drugs* or medications.
3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. See your MEDICAL BENEFIT section.
4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices.
5. Professional charges in connection with administering, injecting or dispensing of *drugs*.
6. *Drugs* and medications which may be obtained without a *physician's* written prescription, except insulin or niacin for cholesterol lowering.
7. *Drugs* and medications dispensed by or while you are confined in a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*.
8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED.
9. Services or supplies for which you are not charged.
10. Oxygen.
11. Cosmetics and health or beauty aids.
12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or experimental *drugs*. *Drugs* or medications prescribed for experimental indications.
13. Any expense incurred for a *drug* or medication in excess of: (i) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies*; or (ii) the *negotiated drug fee*, for *drugs* dispensed by *participating pharmacies* or through the mail service program.
14. *Drugs* which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration.
15. Smoking cessation *drugs*.
16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles).
17. *Drugs* used primarily for the purpose of treating *infertility* (including but not limited to Clomid, Pergonal, and Metrodin).
18. Anorexiant and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).
19. *Drugs* obtained outside of the United States.
20. Allergy desensitization products or allergy serum.

21. Infusion *drugs*, except *self-administered injectable drugs*.
22. Herbal, nutritional and dietary supplements except formulas prescribed by a *physician* for the treatment of phenylketonuria.
23. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.
24. Fertility drugs.
25. Mail order drugs not obtained through the NEXT-RX mail order program.
26. Drugs included in the Specialty Pharmacy prescription drug list not obtained through the Specialty Pharmacy program.

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 *beneficiary*, per calendar 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 our payment, the total value of Allowable Expense as provided under This plan and all Other Plans will not exceed the greater of: (i) the amount which the *plan* would determine to be eligible expense, if you were covered under This Plan only; or (ii) 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; or
3. Group coverage under labor-management trusteed 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 a *Medicare beneficiary* and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to *Medicare's* rules, *Medicare* pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as an employee.
3. For a *dependent child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But 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 under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, 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.
 5. 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.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. *We* are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

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 our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, *we* have the right to pay that Other Plan any amount *we* determine 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 our 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, *we* have 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 MEDICARE ELIGIBLE BENEFICIARIES

For Participating Employers With Fewer Than 20 Employees. If you incur *covered expense* under this *plan*, the *claims administrator* will determine payment and then subtract the amount of benefits from *Medicare* Parts A and B. The *plan* will pay the amount that remains after subtracting *Medicare's* benefit. Please note, the *plan* will not pay any benefit when *Medicare's* payment is equal to or more than the amount which the *plan* would have paid in the absence of *Medicare*.

The *plan* will apply this method of payment when you are 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*.

However, if any one *participating employer* in the *plan* has 100 or more employees (according to OBRA legislation), *beneficiaries* who are entitled to *Medicare* benefits as disabled persons, who have a current employment status, as determined by *Medicare* rules, will receive the full benefits of this *plan*.

For Participating Employers With At Least 20 Employees. *Beneficiaries* eligible for *Medicare* receive the full benefits of this *plan*, except for those *beneficiaries* listed below:

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

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

If a beneficiary is eligible for Medicare and to receive Medicare Part A on a premium-free basis, the *plan* will pay secondary to either a) actual Medicare benefits if that person is enrolled in Medicare Part A or b) estimated Medicare benefits if that person does not enroll in Medicare Part A. If the member is eligible for Medicare but not eligible to receive Medicare Part A on a premium-free basis, the plan will pay secondary to actual Medicare benefits if the beneficiary enrolls in Medicare Part A and primary to Medicare if the member does not enroll in Medicare Part A.

If a beneficiary is not eligible for Medicare, that beneficiary may request an exception to have the plan pay primary.

For Example. Say exception 1 or 2 applies to you, and you are billed for **\$100** of *covered expense*. And say in the absence of *Medicare*, the *plan* would have paid **\$80**. If *Medicare* pays **\$50**, the *claims administrator* would subtract that amount from the **\$80** and pay **\$30**. However, if in this same example, *Medicare's* payment is **\$80** or more, the *plan* will not pay a benefit. Any combined benefit from *Medicare* and the *plan* will equal, but not exceed, what the *plan* would have paid if you were not eligible for *Medicare*.

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization and Case Management are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense. The utilization review program applies to *hospital* admissions, and to outpatient surgery at an *ambulatory surgical center*. The authorization program applies to certain specialized services or treatments. The personal case management program helps you coordinate and manage long-term intensive medical care.

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. Medical management 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*.

UTILIZATION REVIEW PROGRAM

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” portion of UTILIZATION REVIEW PROGRAM.

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

1. All inpatient *hospital stays*; and
2. Outpatient surgery at an *ambulatory surgical center*.

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

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

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency *hospital* admissions and *ambulatory surgical center* services.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or 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-authorization, 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 a *hospital* admission or outpatient surgical procedure at an *ambulatory surgical center*, the benefits to which you would have been otherwise entitled will be reduced by 40% and subject to the \$250 Non-Certification Deductible shown in the SUMMARY OF BENEFITS.
2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. 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. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed.

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.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call us directly. The toll-free number for pre-authorization and pre-service review is printed on your identification card.
3. 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.

4. 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, your *physician* 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, unless extraordinary circumstances* prevent such notification within that time period.
2. When *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll-free number printed on your identification card or you may call directly.
3. When it is determined that the service is *medically necessary* and appropriate, the *claims administrator* 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.
4. 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 our decision. You and your *physician* will receive written notice no later than one business day following our decision.

* **Extraordinary Circumstances.** In determining “extraordinary circumstances,” the *claims administrator* may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify the *claims administrator* for you. You may have to prove that such “extraordinary circumstances” were present at the time of the *emergency*.

Retrospective Reviews.

1. Retrospective review is performed when the *claims administrator* is not notified of the service you received, and is 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.

AUTHORIZATION PROGRAM

The authorization program provides prior authorization for medical care or service by a *non-participating provider*, and for certain “special services.”

It is your responsibility to obtain authorization before you receive any service subject to the authorization program. The toll-free number to call for authorization is shown on your plan identification card.

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” portion of AUTHORIZATION PROGRAM.

SERVICES REQUIRING AUTHORIZATION

Authorized Referrals. In order for the maximum benefits of this *plan* to be payable, advance authorization is required for services received from *non-participating providers*. When the appropriate authorization is obtained, these services are called *authorized referral* services.

NOTE. *Authorized referrals* are not required for the services of *physicians* of a type not available within the *plan* network. A *physician’s* written referral is required, however, in order for the services of some *physicians* to be covered under this *plan*. Refer to the definition of “Physician” in the DEFINITIONS section.

Special Services.

1. Organ and tissue transplants.
2. Travel expense benefits.
3. 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.
4. Home infusion therapy.
5. Home health care.
6. Admissions to a *skilled nursing facility*.
7. Advanced imaging, including but not limited to magnetic resonance imaging (MRI), computed axial tomography (CAT or CT scan) and positron emission tomography (PET scan).

EFFECT ON BENEFITS

For Services Requiring Authorized Referral.

1. The *co-insurance* for *participating providers* will apply for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider*.
2. The *co-insurance* for *non-participating providers* will apply for referral services received from *non-participating providers* that have not been authorized in advance.

For Special Services. Benefits for special services subject to prior authorization will be provided as stated in this *plan* for the specific service only when authorization has been obtained as required. No benefits are payable for unauthorized special services.

WHEN AUTHORIZATION WILL BE PROVIDED

Authorized Referrals. Referrals to *non-participating providers* will be authorized only when all of the following criteria are met:

1. There is no *participating provider* who practices the appropriate specialty or provides the required services or has the necessary facilities within a 50-mile radius of your residence;
2. You are referred to the *non-participating provider* by a *physician* who is a *participating provider*; and
3. The services are authorized as *medically necessary* before services are received.

Special Services.

1. **Home Health Care.** Authorizations for home health care services will be provided only if the following criteria are met:
 - a. The services are *medically necessary* and appropriate and can be safely provided in the *beneficiary's* home, as certified by the attending *physician*;
 - b. The attending *physician* manages and directs the *beneficiary's* medical care at home; and
 - c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *beneficiary's* medical needs and must list the services to be provided by the *home health agency*.
2. **Home Infusion Therapy.** Authorizations for services by a *home infusion therapy provider* will be provided only if the following criteria are met:
 - a. The services are *medically necessary* and appropriate; and
 - b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services being rendered.
3. **Organ and Tissue Transplants.** Authorizations for organ and tissue transplants will be provided as follows:
 - a. For kidney, bone, skin or cornea transplants, only if both of the following criteria are met:
 - i. The services are *medically necessary* and appropriate; and
 - ii. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, only if all of the following criteria are met:
 - i. The services are *medically necessary* and appropriate; and
 - ii. The providers of related preoperative and postoperative services are approved.

4. **Physical Therapy, Physical Medicine and Occupational Therapy (including Chiropractic Care).** The number of visits for physical therapy, physical medicine and occupational therapy which are payable without prior authorization is stated in the “Physical Therapy, Physical Medicine or Occupational Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specific number of additional visits will be authorized when:
 - a. Additional visits are *medically necessary* and appropriate and likely to result in a significant improvement in your condition; and
 - b. You or your *physician* requests approval for the additional benefits prior to those services being rendered.
5. **Skilled Nursing Facility.** The *claims administrator* will authorize inpatient services provided in a *skilled nursing facility* if:
 - a. You require daily skilled nursing or rehabilitation, as certified by the attending *physician*;
 - b. You were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and
 - c. You will be treated for the same condition for which you were treated in the *hospital*.
6. **Transplant Travel Expense Benefits.** Authorizations for transplant travel expense benefits will be provided for the recipient or donor only if all of the following criteria are met:
 - a. It is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, authorized by us;
 - b. The organ transplant must be performed at a specific *COE*; and
 - c. The specific *COE* is 250 miles or more from the recipient or donor’s home.
7. **Bariatric Travel Expense.** The following travel expense benefits will be provided in connection with a covered *COE* surgical procedure only when the *member’s* home is fifty (50) miles or more from the nearest *COE*. All travel expenses must be approved by Anthem Blue Cross in advance.
 - Transportation for the *member* to and from the *COE* up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
 - Transportation for one companion to and from the *COE* up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
 - Hotel accommodations for the *member* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
 - Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *member’s* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.

- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric *COE*. Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

HOW TO OBTAIN AN AUTHORIZATION

For Authorized Referrals. You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

For Special Services Authorizations. You or your *physician* must call the toll-free telephone number printed on your identification card before the services are rendered.

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 our review process.

1. A decision on the medical necessity of a pre-service request will be made no later than two business days from receipt of the information necessary to make the decision.
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 necessary to make the decision.
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.
4. If the *claims administrator* does not have the information needed, 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-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and 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 certified as *medically necessary* will be sent to you and your provider no later than two business days from the decision.
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 telephonically 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 telephonically 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 one business day of the decision. This written notice will include:

- a. An explanation of the reason for the decision;
 - b. Reference of the criteria used in the decision to modify or not certify the request;
 - c. The name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request; and
 - d. 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:

- a. The information submitted with the claim differs from that given by phone;
- b. The service is excluded from coverage; or
- c. 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 administrator* makes 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. 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.
2. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *beneficiary*.
3. 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.

QUALITY ASSURANCE

Medical management 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 time frames for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Resource Management Committee, Quality Management Committee, and Physician Relation's 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 time frames. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Plan Participants.** Persons described in the *subscription agreement* between the *trust* and the *participating employer* are eligible to enroll as *plan participants*.
2. **Dependents.** The following are eligible to enroll as *dependents*: (i) The *plan participant's spouse* or *domestic partner*; and (ii) A *child*.

Definition of Dependent.

1. **Spouse** is the *plan participant's spouse* under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (i) covered as a *plan participant* or *domestic partner*; or (ii) in active service in the armed forces.
2. **Domestic partner** is the *plan participant's domestic partner* whose domestic partnership is currently registered with a governmental body pursuant to state or local law. *Domestic partner* does not include any person who is: (i) covered as a *plan participant* or *spouse*; or (ii) in active service in the armed forces.

For the purposes of this definition, in lieu of being currently registered with a governmental body, the *plan participant* and his or her *domestic partner* may provide the *participating employer* with a signed, notarized, affidavit certifying, under penalty of perjury, that:

- a. They have an intimate, committed relationship of mutual caring;
- b. They share the same principal residence(s);
- c. They agree to be responsible for each other's basic living expenses during their domestic partnership; and also agree that anyone who is owed these expenses can collect from either of them;
- d. They are both 18 years of age or older;
- e. Neither of them is legally married;
- f. They are not so closely related by blood that legal marriage would otherwise be prohibited;
- g. Neither of them has a different *domestic partner* now; and
- h. Neither of them has had a different *domestic partner* in the last twelve months (this last condition does not apply to a person who had a partner who died).

The *plan* provides coverage for *domestic partners* that is equal to the coverage provided to *spouses*.

3. **Child** is the *plan participant's, spouse's or domestic partner's* natural child, stepchild, or legally adopted child, subject to the following:
 - a. 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 *plan participant, spouse or 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 *plan participant's, the spouse's or domestic partner's* right to control the health care of the child.
 - b. The term "child" does not include: (i) any child for whom the *plan participant, spouse or domestic partner* is the legal guardian, but who is not the *plan participant's, spouse's or domestic partner's* natural child, stepchild or adopted child; (ii) any person who is covered as a subscriber; or (iii) any person who is in active service in the armed forces.
 - c. If both parents are covered as *plan participants*, their children may be covered as the family members of either, but not of both.
 - d. The child must not have attained the age of 26.
 - e. The child is 26 years of age, or more and: (i) was covered by the *plan* at the end of the previous *plan* year, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *plan participant, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 31-days of the date the child first becomes eligible under this *plan*. After a period of two years has passed from the initial certification to us, we may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year. This exception will last until the child is no longer chiefly dependent on the *plan participant, spouse or domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

ELIGIBILITY DATE

1. For *plan participants*, you become eligible for coverage at the end of any probationary or waiting period imposed by your *participating employer*. The *plan* does not impose any probationary or waiting period.
2. For *dependents*, you become eligible for coverage on the later of: (i) the date the *plan participant* becomes eligible for coverage; or (ii) the date you meet the *dependent* definition.

Enrollment. To enroll as a *plan participant*, or to enroll *dependents*, the *plan participant* must properly file an application. An application is considered properly filed, only if it is personally

signed, dated, and given to the *plan agent* within 31 days from your eligibility date. 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 *plan participants*, on the first of the month following your eligibility date as determined by your *participating employer*; and
 - b. For *dependents*, on the later of:
 - i. The date the *plan participant'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 an employee files an enrollment application or membership change form with the *plan agent* requesting enrollment for a *spouse, child* or *domestic partner* more than 31 days after the initial eligibility date, the employee must submit a properly completed health statement for all persons listed on that application or change form with evidence of good health, except as provided under the heading Exceptions to Late Enrollment below. For a health statement to be considered properly completed, each section of the statement must be signed, dated and filled out in its entirety. Coverage will commence only if the *plan agent* approves such evidence.

If approved, coverage begins on the first day of the month following underwriting approval. If not approved, the employee will be eligible to reapply for coverage as set forth under the heading Application for Enrollment above, without submitting a health statement, as of the first day of the month coinciding with or following 12 months from the date of the previous application. The employee is responsible for the cost of obtaining any required health evidence. The *plan* will not be liable for any of this cost.

3. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the “Late Enrollment” provision above, or during the next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Exceptions to Late Enrollment. An individual eligible to enroll as a plan participant or dependent may enroll without submitting health evidence later than 31 days after the eligibility date if he is not

considered a late enrollee. Such an individual will not be considered a late enrollee status if the following is applicable:

1. The individual meets all of the following requirements:

a) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program at the time the individual was eligible to enroll.

b) Such individual certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or the Medi-Cal program was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification as required by applicable law and was notified that failure to do so could result in later treatment as a late enrollee.

c) Such individual has lost or will lose coverage under another employer benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a *dependent*, change in employment status of the individual, or of a person through whom the individual was covered as a dependent, the termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program.

d) Such individual requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

2. The individual is employed by a *Participating Employer* who offers health benefit plans from carriers other than the *Trust* and the individual elects the *Plan* during an open enrollment period.

3. A court has ordered that coverage be provided for a spouse or minor child under a *Plan Participant's* health benefit plan.

4. In the case of an individual eligible to enroll as a *Plan Participant* the *Trust* cannot produce the certification regarding previous declination of coverage required by applicable law.

5. The individual meets the criteria described in paragraph (1) and was under a *COBRA* or *Cal Cobra* continuation provision and the coverage under that provision has been exhausted.

6. The individual is a dependent of a Participant Employer who has lost or will lose his or her coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program and requests enrollment within 60 days after termination of the coverage.

7. The individual is an employee eligible to be a Plan Participant who previously declined coverage and who has subsequently acquired a *dependent* who would be eligible for coverage as a dependent through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage on his or her behalf, and on behalf of his or her *dependent* within 30 days following the date of marriage,

birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided at or before the time the individual is offered an opportunity to enroll in plan coverage.

8. The individual is an employee eligible to be a *Plan Participant* who has declined coverage for himself or herself or his or her *dependents* during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her *dependents* for plan coverage during a special open enrollment opportunity if his or her *dependents* have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided at or before the time the employee is offered an opportunity to enroll in *plan* coverage.

Important Note for Newborn and Newly-Adopted Children. If *plan participant* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered:

1. Any *child* born to the *plan participant*, *spouse* or *domestic partner* will be covered from the moment of birth; and

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.

2. Any *child* being adopted by the *plan participant*, *spouse* or *domestic partner* will be covered from the date on which either:

a) The adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *plan participant*, *spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *plan participant's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used); or

b) The *plan participant*, *spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption.

The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

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

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.

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 and you were given written notice that if you choose to enroll later, you may be required to wait until the next open enrollment period to do so;
 - 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; and
 - d. You properly filed an application with the *plan agent* 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 *plan agent* 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 the end of the next open enrollment period.
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.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as an employee of a Participating Employer with two or more employees under this *plan* may enroll. An employee may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *plan participant's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

Changes from one plan design to another may be effected only at open enrollment, unless otherwise required by the Trust.

SPECIAL RULES APPLICABLE TO EMPLOYERS WITH NO EMPLOYEES (GROUPS OF ONE)

Applicants in this category are subject to special rules. Such rules apply differently to *CalCPA members* who are *federally eligible defined individuals* and *CalCPA members* who do not fit such definition. A *federally eligible defined individual* is guaranteed eligibility after underwriting on the *plan's* open enrollment date. He or she is also guaranteed eligibility after underwriting on any other date. However, in the event the *plan* deems such individual to be high-risk after underwriting, a special high-risk rating plan will apply to such individual. An individual who is not a *federally eligible defined individual* may enroll at any time if after underwriting the *plan* deems that such individual meets the *plan's* risk criteria.

For rating purposes, the *CalCPA member* will always be the employee and the spouse will be covered as a dependent.

Plan participants in the group of one category are not eligible for *COBRA* or *CalCOBRA* coverage.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the *plan* terminates, your coverage ends at the same time. This *plan* may be canceled or changed without notice to you.
2. If the *plan* no longer provides coverage for the class of *beneficiaries* to which you belong, your coverage ends on the *effective date* of that change. If this *plan* is amended to delete coverage for *dependents*, a *dependent's* coverage ends on the *effective date* of that change.
3. Coverage for *dependents* ends when *plan participant* coverage ends.
4. Coverage ends at the end of the period for which the required monthly contribution has been paid on your behalf when the required monthly contribution for the next period is not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which you provide to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the due date for the required monthly contribution coinciding with or following the date you cease to meet such requirements.

Exception to Item 6.

Handicapped Children. If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is: (i) covered under this *plan*; (ii) still financially dependent on the *plan participant*, *spouse* or *domestic partner*; and (iii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. We must receive the certification, at no expense to us, within 31 days of the date the *child* otherwise becomes ineligible.

When a period of two years has passed, we may request proof of continuing dependency and disability, but not more often than once each year. This exception will last until the *child* is no longer handicapped or dependent on the *plan participant*, *spouse* or *domestic partner* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

Leave of Absence. The end of coverage may at the option of a Participating Employer be postponed for up to six months in the event the employer grants a leave of absence and premiums are paid as otherwise required.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CONTINUATION OF COVERAGE (*CalCOBRA*), EXTENSION OF BENEFITS and HIPAA COVERAGE.

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 agent* 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: (i) 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 (ii) a *child* who is born to or placed for adoption with the *plan participant* during the *COBRA* continuation period. Qualified Beneficiary does not include 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. It does not include *domestic partners* 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 *plan participant's* termination of employment, for any reason other than gross misconduct; or
- b. A reduction in the *plan participant's* work hours.

2. For Dependents.

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

ELIGIBILITY FOR COBRA CONTINUATION

An employee or *dependent* may choose to continue coverage under the *plan* if his or her coverage would otherwise end for a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *participating employer* will notify either the *plan participant* or *dependent* of the right to continue coverage under *COBRA*, as provided below:

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

If you choose to continue coverage you must notify the *participating employer* within 60 days following the later of: (i) the date coverage under the *plan* terminates; or (ii) the date you receive notification of the ability to continue coverage. This is the Initial Enrollment Period. Your request must be in writing and delivered by first-class mail or other reliable means of delivery. *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 agent* each month during the *COBRA* continuation period.

Besides applying to the *plan participant*, the *plan participant’s* rate also applies to:

1. A *spouse* whose *COBRA* continuation began due to divorce, separation or death of the *plan participant*;
2. A *child* if neither the *plan participant* 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, a *plan participant* 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 *plan participant'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 *plan participant*, divorce or legal separation, or the end of *dependent child* status;*
3. The end of 36 months from the date the *plan participant* became entitled to *Medicare*, if the Qualifying Event was the *plan participant'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 *plan participant* will end 36 months from the date the *plan participant* 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;
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; or
8. The date the *COBRA participating employer*, or any successor employer or purchaser of the *COBRA participating employer*, ceases to provide any group health benefit plan.

* For a *beneficiary* whose *COBRA* continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*.

Subject to the *plan* remaining in effect, a retired *plan participant* 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 *plan participant's* death. But coverage could terminate prior to such time for either the *plan participant* or *dependent* in accordance with items 4, 5 or 6 above.

You are entitled (subject to *CalCOBRA* rules) to continuation of coverage under *CalCOBRA* if your *COBRA* continuation ends less than 36 months after the Qualifying Event. For applicable *CalCOBRA* rules, see Continuation of Coverage (*CalCOBRA*).

If your *COBRA* and/or *CalCOBRA* continuation under this *plan* ends in accordance with items 1, 2, 3 or 4, you may be eligible for HIPAA coverage. The *plan* will provide notice of these options within 180 days prior to your *COBRA* termination date. Please see HIPAA COVERAGE 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.⁷

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 agent* 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 date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the 19th through 29th months that you continue to be totally disabled, the cost (called the "required monthly contribution") shall be subject to the following conditions:

1. If the disabled *beneficiary* continues coverage during this extension, this rate 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 each month during the period of extended continuation coverage. We must receive timely payment of the premium each month 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 premium rate 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;
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; or
7. The date the *COBRA participating employer*, or any successor employer or purchaser of the *COBRA participating employer*, ceases to provide any group health benefit plan.

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

If a beneficiary entitled to *COBRA* benefits on or after January 1, 2004, after the extension ends, then the beneficiary may elect *CalCOBRA* coverage if the beneficiary's period of *COBRA* coverage is ended because the beneficiary has exhausted an 18- or 29-month period of *COBRA* coverage. In such event, the beneficiary may elect *CalCOBRA* coverage until his or her coverage under *COBRA* and *CalCOBRA* have totaled 36 months, unless terminated sooner under *CalCOBRA* rules.

CONTINUATION OF COVERAGE (CALCOBRA)

If the employer employs at least two but no more than 19 eligible employees on a typical business day, and is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (*COBRA*), you may qualify for continuation of coverage in accordance with the California Continuation Benefits Replacement Act (*CalCOBRA*).¹

Initial Enrollment Period is the period of time following the Qualifying Event, as indicated in the “Terms of *CalCOBRA* Continuation” provisions below, during which you may elect continuation of coverage under *CalCOBRA*.

Qualified Beneficiary means: (i) a person enrolled for this *CalCOBRA* continuation coverage who, on the date of the Qualifying Event, was covered under this *plan* as either a *plan participant* or *dependent*; and (ii) a *child* who is born to or placed for adoption with the *plan participant* during the *CalCOBRA* continuation period, and who is enrolled in the *plan* as a *dependent* within 30 days of the *child’s* birth or placement for adoption. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the *CalCOBRA* continuation period, with the exception of newborns and adoptees as specified above.

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 Subscribers and Dependents.

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

2. For Dependents.

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

ELIGIBILITY FOR CALCOBRA CONTINUATION

You may choose to continue coverage under the *plan* if your coverage would otherwise end due to a Qualifying Event.

¹ You are also entitled to *CalCOBRA* continuation if your employer is subject to *COBRA*, you elected *COBRA* continuation, and such continuation has been exhausted. Any *CalCOBRA* continuation you elect expires no later than 36 months after the Qualifying Event.

Exceptions. You are not entitled to continue coverage if, at the time of the Qualifying Event, you are: (i) entitled to *Medicare*; (ii) covered under any other health plan, other than a health plan that contains an exclusion or limitation relating to a *pre-existing condition*, unless that exclusion or limitation does not apply or has been satisfied pursuant to California law; or (iii) eligible for or covered under a continuation of coverage through federal *COBRA*. If one *beneficiary* is unable to continue coverage for these reasons, other entitled *beneficiaries* may still choose to continue their coverage.

TERMS OF CALCOBRA CONTINUATION

Notice. The *participating employer* will notify either the *plan participant* or *dependent* of the right to continue coverage under *CalCOBRA*, as provided below:

1. For Qualifying Event 1(a) or 1(b), the *participating employer* will notify the *plan participant* of the right to continue coverage.
2. You must inform the *participating employer* in writing within 60 days of Qualifying Events 2(a), 2(b), 2(c) or 2(d) if you wish to continue coverage. Failure to make this notification will disqualify you from receiving continuation coverage under *CalCOBRA*. The *participating employer* in turn will promptly give you official notice of your *CalCOBRA* continuation right.

If you choose to continue coverage you must notify the *participating employer* within 60 days following the later of: (i) the date coverage under the *plan* terminates; or (ii) the date you receive notification of the ability to continue coverage. This is the Initial Enrollment Period. Your request must be in writing and delivered by first-class mail or other reliable means of delivery. *CalCOBRA* continuation coverage may be chosen for all *beneficiaries* within a family, or only for selected *beneficiaries*.

If you do not elect *CalCOBRA* continuation during the Initial Enrollment Period, you may not elect it at a later date.

Payment of the initial required monthly contribution must be delivered within 45 days after you elect *CalCOBRA* continuation coverage. You must make this payment to the *participating employer* by certified mail or other reliable means of delivery, in an amount sufficient to pay any required monthly contributions due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under *CalCOBRA*.

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

Cost of Coverage. You may be required to pay the entire cost of your *CalCOBRA* continuation coverage. This cost, called the “required monthly contributions,” shall be 110% of the applicable group rate, and must be remitted each month during the *CalCOBRA* continuation period. We must receive payment of the required monthly contribution each month in order to maintain the coverage in force.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. *We* shall rely upon the latest information received as correct without verification; but *we* maintain the right to verify any eligibility information you provide.

When CalCOBRA Continuation Coverage Begins. When *CalCOBRA* 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 Qualifying Event, so that no break in coverage occurs.

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

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

1. The end of 36 months from the Qualifying Event;
2. The date the *plan* terminates;
3. The end of the period for which required monthly contributions are last paid;
4. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a *pre-existing condition* that you have. In this case, this continuation will end at the end of the period for which the *pre-existing condition* exclusion or limitation applied;
5. The date you become entitled to *Medicare*; or
6. The date you become covered under a federal *COBRA* continuation.

CalCOBRA continuation will also end if you move out of our service area or if you commit fraud.

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

EXTENSION OF BENEFITS

If you are a *totally disabled plan participant* 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. *We* 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 up to 12 months has passed since your extension began.

POST-COBRA AND -CALCOBRA CONTINUATION FOR QUALIFYING MEMBERS

Subject to payment of required monthly contributions as stated in the *plan*, coverage under this *plan* may be continued for the *plan participant*, the *plan participant's spouse*, and the *plan participant's former spouse* (if any) under Section 10116.5 of the Insurance Code, in accordance with the following provisions. This continuation benefit applies only if you were eligible for it prior to January 1, 2005. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the California Continuation Benefits Replacement Act).

For the purposes of this section, “former *spouse*” means: (i) an individual who is divorced from the *plan participant*; or (ii) an individual who was married to the *plan participant* at the time of the *plan participant's* death.

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

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

* *COBRA* and/or *CalCOBRA* continuation coverage must be both elected and exhausted in order for this further continuation to be available.

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

For the *plan participant* and *spouse*, this continuation may be chosen for both, for the *plan participant* 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 *participating employer* in writing within 30 days prior to the date continuation coverage under *COBRA* and/or *CalCOBRA* 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 contributions to the employer at the time the required monthly contribution is due. You may be required to pay the entire cost of your continuation coverage. The timely payment of required monthly contributions are due for the continuation of your coverage under this *plan*. The rate for continuation coverage under this section shall be 102% for *COBRA*-eligible, and 110% for *CalCOBRA*-eligible, participants of the applicable rate. For the purpose of determining required monthly contributions payable, the *spouse* or former spouse continuing coverage alone will be considered to be a *plan participant*.

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

1. The end of the period for which required monthly contributions are last paid;
2. The date the *plan* terminates;
3. The date the *plan participant*, *spouse*, or former *spouse* becomes covered under any other health plan;
4. The date the *plan participant*, *spouse*, or former *spouse* becomes entitled to *Medicare*;
5. The date the *plan participant*, *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* and/or *CalCOBRA* continuation coverage ended.

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 in this booklet for more information.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at any time during the first 60 days of the *CalCOBRA* 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 Qualifying Event.

Notice. You must furnish us with proof of the Social Security Administration's determination of disability during the first 18 months of the *CalCOBRA* continuation period and no later than 60 days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the 19th through 29th months that you continue to be totally disabled, the cost (called the "required monthly contribution") shall be subject to the following conditions:

1. This charge shall be **150%** of the applicable rate, depending upon the number of covered *dependents*, and must be remitted each month during the period of extended continuation coverage.
2. You may be required to pay the entire cost of the extended continuation coverage.
3. *We* must receive timely payment of the required monthly contributions each month in order to maintain the extended continuation coverage in force.

If a second Qualifying Event occurs during this extended continuation, the total *CalCOBRA* continuation may continue 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.

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

1. The end of the month following a period of 31 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 you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a *pre-existing condition* that you have. In this case, this continuation will end at the end of the period for which the *pre-existing condition* exclusion or limitation applied;
6. The date you become entitled to *Medicare*; or
7. The date you become covered under a federal *COBRA* continuation.

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

If continuation coverage ends due to items 2 or 7 above, a surviving *spouse* and *dependents* are eligible for the coverage specified in this *plan* under COVERAGE FOR SURVIVING DEPENDENTS.

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. HIPAA coverage is available upon request if you meet the requirements stated below. HIPAA coverage is available for medical benefits only. Please note that the benefits and cost of these plans will differ from your current employer's *plan*. Also please note, HIPAA coverage is available from the *trust*, only for persons eligible to be a *plan participant*.

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 *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 a group health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of required monthly contributions or fraud.
3. If continuation of coverage under the *plan* was available under *COBRA*, *CalCOBRA*, or a similar state program including *Post-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 *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

When coverage under the *plan* ends, you will receive more information about how to apply for HIPAA coverage, including a postcard for requesting an application and a telephone number to call if you have any questions.

ELIGIBILITY OF SURVIVING FAMILY MEMBERS TO ELECT CONTINUATION COVERAGE

In the event of the death of a *plan participant*, if surviving *family members* of the *plan participant* were covered as qualified beneficiaries under *COBRA* or *CalCOBRA*, the surviving *family members* may further continue benefits beyond the date that coverage under post *COBRA* or post *CalCOBRA* ends. Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under post *COBRA* or post *CalCOBRA* had remained in force, and shall be subject to the following:

1. Only surviving eligible *family members* are eligible for continuation coverage under this section.
2. Subscription charges for continuation coverage are payable by the surviving *spouse* or, if none, by each of the other surviving *family members*.
3. Continuation coverage will continue until the earliest of the following dates:
 - a. The date the individual(s) reaches age 65;
 - b. The date the surviving *spouse* remarries;
 - c. The date the individual(s) becomes covered under any other group health plan regardless of whether that coverage is less valuable;
 - d. The date the individual(s) becomes entitled to *Medicare*; or
 - e. The first of the month for which the surviving *spouse* or eligible child(ren) fails to make the required payment for the continuation coverage.

In the event of the death of a *plan participant* who was not eligible for *COBRA* or *CalCOBRA*, continuation coverage will be available for surviving *family members* under the rules stated above to the extent such surviving *family members* satisfy the definition of qualified beneficiaries under *COBRA* or *CalCOBRA*.

GENERAL PROVISIONS

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, *we* refund the unearned part of the required monthly contribution paid. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this *plan*.

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

Continuity of Care. If the *claims administrator* terminates its contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

Expense in Excess of Benefits. *We* are not liable for any expense you incur in excess of the benefits of this *plan*.

Financial Arrangements with Providers. The *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 the *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that the *claims administrator* or its affiliates offer several types of products and programs. The *members*, *beneficiaries* and *plan 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 the *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 the *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 the *claims administrator* or an affiliate in determining its fees or subscription charges or premiums.

Free Choice of Provider. This *plan* in no way interferes with your right as a *beneficiary* 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*.

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor is *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital*, medical group or medical care provider of any type.

Liability of Employee 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 *claims administrator* owes to that provider (not including *co-payments* or deductibles), even in the unlikely event that the administrator does not pay the provider. You may be liable, however, to pay *non-participating providers* any amounts not paid to them under the *plan*.

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. The process used to authorize or deny health care services under this *plan* is available to you upon request.

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*.

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 *contracting hospitals*, *participating providers*, *COE* and medical transportation providers. Also, *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the *plan's* obligation to you for those covered services.

Plan Administrator - COBRA and ERISA. In no event will the *claims administrator* be *plan administrator* for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term “*plan administrator*” refers to the BOARD OF TRUSTEES OF THE GROUP INSURANCE TRUST OF THE CALIFORNIA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS or to a person or entity other than the *claims administrator*, engaged by GROUP INSURANCE TRUST OF THE CALIFORNIA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS to perform or assist in performing administrative tasks in connection with the *plan*. The *plan administrator* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this *Medical Plan Document and Disclosure Form*, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (i) this *plan* is in effect; (ii) you are eligible; and (iii) your required monthly contributions are paid according to the terms of the *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 the *claims administrator*, 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.

Providing of Care. We are not responsible for providing any type of *hospital*, medical or similar care, nor are we responsible for the quality of any such care received.

Renewal Provisions. The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

Right of Recovery. When the amount paid exceeds our liability under this *plan*, we have 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.

Terms of Coverage.

1. In order for you to be entitled to benefits under the *plan*, both the *plan* 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 *plan* without your consent or concurrence.

Workers' Compensation Insurance. The *plan* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance, or provide benefits for individuals that do not purchase worker's compensation insurance coverage.

REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because the *claims administrator* determines that the treatment is *experimental* or *investigative*, the *member* may ask that the denial be reviewed by an external independent medical review organization with which the *claims administrator* contracts. To request this review, the *member* should call the *claims administrator* at the address shown under the Notice of Claim section. To receive this review, all of the following conditions must be met:

1. The *member* must have a *life-threatening* condition or a seriously debilitating condition.
2. The *member's physician* certifies that the *member* has a condition for which standard therapies have not been effective in improving the condition of the *member*, for which standard therapies would not be medically appropriate for the *member*, or for which there is no more beneficial standard therapy covered by the *plan* than the therapy proposed pursuant to paragraph 3 below.
3. Either:
 - a. The *member's physician* has recommended a drug, device, procedure, or other therapy that the *physician* certifies in writing is likely to be more beneficial to the *member* than any available standard therapies; or
 - b. The *member*, or the *member's physician* who is a licensed, board-certified or board-eligible *physician* qualified to practice in the area of practice appropriate to treat the *member's* condition, has certified to or requested a therapy that, based on two documents from the medical and scientific evidence, as defined below, is likely to be more beneficial for the *member* than any available standard therapy.

The *physician's* certification shall include a statement describing the evidence relied upon by the *physician* in certifying his or her recommendation. The *plan* shall not be required to pay for the services of a *non-participating provider* that are not otherwise covered pursuant to the contract.

4. The *member* has been denied coverage by the *claims administrator* for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph 3, unless coverage for the specific therapy is excluded by the *Medical Plan Document and Disclosure Form*.
5. The specific drug, device, procedure, or other therapy recommended by the *physician* for the *member* pursuant to paragraph 3 would be a covered service except for the *claims administrator's* determination that the therapy is experimental or under investigation.

The *plan* shall offer all *members* who meet the above criteria the opportunity to have the requested therapy reviewed under the external independent review process. The *plan* shall notify the *member* of this opportunity within five business days after the decision to deny coverage.

If this review is requested either by a *member* or by a *physician*, the requestor must supply two items of acceptable medical and scientific evidence. This evidence should be obtained from one or more of the following sources:

1. Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
2. Medical literature meeting a criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
4. The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug information;
5. Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
6. Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five days of receiving a request for review, the *claims administrator* will send the reviewing panel all relevant medical records and documents in its possession, as well as any additional information submitted by the *member* or by his or her *physician*. Information the *claims administrator* receives subsequently will be sent to the review panel within five business days of its receipt. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of a request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

A *member* may request an independent medical review (“IMR”) of disputed health care services from the California Department of Insurance if he or she believes that the *plan* has improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the *member’s* coverage that has been denied, modified, or delayed by the *plan*, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The *member* has the right to provide information in support of the request for an IMR. The *plan* must provide the *member* with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a *member* to forfeit any California statutory right to pursue legal action against the *plan* regarding the disputed health care service. It should be noted that the *plan* does not believe any such California statutory right exists which is applicable to it. For more information regarding the IMR process, or to request an application form, please call the *plan agent*.

Eligibility. The California Department of Insurance will review the *member’s* application for an IMR to confirm that:

1. a. The provider has recommended a health care service as *medically necessary*.
b. The *member* has received *urgent care* or *emergency services* that a provider determined was *medically necessary*; or
c. The member has been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which he or she seeks independent review.
2. The disputed health care service has been denied, modified, or delayed by the *claims administrator* based in whole or in part on a decision that the health care service is not *medically necessary*; and
3. The *member* filed a grievance with the *plan agent* and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the *member* may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the *member* follow the *plan’s* grievance process in extraordinary and compelling cases.

If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is *medically necessary*. The *member* will receive a copy of the assessment made. If the IMR determines the service is *medically necessary*, the *plan* will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the California Department of Insurance must provide its determination within 30 days of receipt of the *member’s* application and supporting documents. For urgent cases involving an imminent and serious threat to a *member’s* health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the *member’s* health, the IMR organization must provide its determination within three business days.

DEFINITIONS

The meanings of key terms used in this booklet 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 booklet, 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.

Acupuncture means the benefits described under the heading Acupuncture.

Adverse Benefit Determination. An *adverse benefit determination* is a denial, reduction, termination or failure to provide or pay (in whole or in part) for a benefit. This includes any such denial, reduction, termination, or failure to provide or make payment that is based on the following: (i) a determination of an individual's *eligibility* to participate in the *plan*; (ii) a determination that a benefit is not a *covered benefit*; (iii) a determination that a benefit is experimental or investigational or not *medically necessary* or appropriate; (iv) the imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion or other limitation on covered benefits and (v) the rescission of coverage (the cancellation or discontinuance of coverage that has a retroactive effect, unless the cancellation is for failure to pay premium), whether or not the rescission has an adverse effect on any particular benefit at the time.

Ambulance Service means the benefits described under the heading Ambulance.

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.

Average Wholesale Price is a term accepted in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

Beneficiary is the *plan participant* or *dependent*.

Board of Trustees is the governing body of the *trust*.

Brand Name Prescription Drug (Brand Name Drug) is a *prescription drug* that has been patented and is only produced by one manufacturer.

CalCOBRA means California Insurance Sections 10128.50.

CalCOBRA Excluded Member means a member with respect to whom any of the following applies. Such member:

1. Is entitled to *Medicare* benefits. Entitlement to *Medicare* Part A only constitutes entitlement to *Medicare* benefits.
2. Is covered under other hospital, medical, or surgical coverage, or is covered under another group benefit plan, a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any *pre-existing condition* limitation or the exclusion or limitation does not apply or is satisfied.
3. Is eligible for or is covered under federal *COBRA* coverage.
4. Is eligible for or is covered under coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq. (Governmental Continuation); or
5. Has failed to notify the *plan*, to elect coverage or to pay initial premiums as set forth under the *CalCOBRA* Notice and Premium Procedure.
6. Has moved out of the service area (California).

CALCOBRA Participating Employer means a *participating employer* with respect to whose *plan participants* the *plan* is required to comply with *CalCOBRA* (2-19 employees).

CalCPA means the California Society of Certified Public Accountants.

Centers of Expertise (COE) are health care providers which have a Centers of Expertise Agreement in effect with the *claims administrator* at the time services are rendered. *COE* agree to accept the *COE negotiated rate* as payment in full for covered services. A *participating provider* in the *plan* network is not necessarily a *COE*. A provider's participation in the *plan* network or other agreement with the *claims administrator* is not a substitute for a Centers of Expertise Agreement.

Centers of Expertise Negotiated Rate (COE Negotiated Rate) is the fee *COEs* agree to accept as payment for covered services. It is usually lower than their normal charge. *COE negotiated rates* are determined by Centers of Expertise Agreements.

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

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

Class I Transplants are any of the following: liver, heart, heart-lung, kidney, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell treatment and similar procedures.

Clone means a copy (perfect or imperfect, living or not living) of a human being or part thereof produced through asexual replication. Notwithstanding any other provision of the *Medical Plan Document and Disclosure Form*, or any other definition set forth in the *Medical Plan Document and Disclosure Form*, in no event shall a *clone* be a *member* of the *plan*, or be deemed to be a *child*, *spouse* or *domestic partner* of a *plan participant*.

Cloning means any act designed to produce a *clone* or leading to the creation of a *clone*.

COBRA (20 or more employees) means the medical plan related provisions of the Consolidated Budget Reconciliation Act of 1985, as such provisions have been subsequently amended.

COBRA Administrator means a *COBRA participating employer* or third party (not the Trustees or the *plan administrator*) appointed by the *COBRA participating employer* to act as the *COBRA Administrator*.

COBRA Participating Employer means a *participating employer* in the *plan* who is required by law to comply with *COBRA*.

Co-Insurance is the amount expressed as a percentage, payable by the *member* for *covered expenses*.

Comprehensive Benefits means all benefits payable by the *plan* for services and supplies other than benefits available under the heading Prescription Drug Benefits.

Concurrent Review occurs during the *member's hospital stay* to determine if continued inpatient care is *medically necessary*.

Contracting Hospital is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *beneficiaries*. A *contracting hospital* is not necessarily a *participating provider*. A list of *contracting hospitals* will be sent on request.

Co-Payment is the amount payable by the *member* for office visits and certain other services. The *prescription drug co-payments* are fixed dollar amounts payable for *prescription drugs*. The term "*co-payment*" does not include the portion of *covered expenses*, expressed as a percentage, payable by the *member* for covered services.

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 coverage under any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under a publicly

sponsored program such as *Medicare* or Medicaid, CHAMPUS, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, or coverage through the Peace Corps. *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.

You are considered to have been covered under a creditable coverage if you:

1. Were covered under a *creditable coverage* on the date that coverage terminated;
2. Were in an eligible status under this *plan* within 63 days of termination of the *creditable coverage*; and
3. Properly enrolled for coverage within 31 days of the eligibility date.

You are also considered to have been covered under a *creditable coverage* if your employment ended, the availability of medical coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward medical coverage terminated, provided that you:

1. Were covered under a *creditable coverage* on the date that coverage terminated;
2. Were in an eligible status under this *plan* within 180 days of termination of the *creditable coverage*; and
3. Properly enrolled for coverage within 31 days of the eligibility date

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 licensed according to state and local laws to provide outpatient programs and treatment of *mental or nervous disorders*, *severe mental disorders*, or *substance abuse* under the supervision of *physicians*.

Declination means the portion of the *enrollment agreement* acknowledging *declination* of coverage.

Deductible means the amount of charges a *member* must pay for any covered services before any benefits are available to the *member* under the *plan*. Amounts applied to the *deductible* do not apply to or reduce any *co-insurance/co-payment*, or the percentage of any *covered expense* or *prescription drug maximum allowed amount* which the *member* must pay.

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

Domestic Partner meets the *plan's* eligibility requirements for *domestic partners* as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Drug (Prescription Drug) means a prescribed drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public. For the purposes of this *plan*, insulin will be considered a prescription drug.

Drug Limited Fee Schedule represents the maximum amounts the *plan* will allow as *prescription drug maximum allowed amount* for *prescriptions* filled at *non-participating pharmacies*. These amounts are the lesser of billed charges or the *average wholesale price*.

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

Eligibility Date for *plan participants* is the date you become eligible for coverage at the end of any probationary or waiting period imposed by your *participating employer*. The *plan* does not impose any probationary or waiting period. For *dependents*, it is the date you become eligible for coverage on the later of: (i) the date the *plan participant* becomes eligible for coverage; or (ii) the date you meet the *dependent* definition.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or (ii) causing serious impairment to bodily functions; or (iii) causing serious dysfunction of any bodily organ or part, each of (i)(ii) and (iii) as more fully described in 42 U.S.C. 1395dd (e)(1) (A).

Emergency services. The term emergency services means, with respect to an emergency medical condition-

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under 42 U.S.C. 1395dd to stabilize the patient.

Enrollment Agreement means the agreement by which a *plan participant* enrolls in the *plan*.

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

Facility-Based Care is care provided in a *hospital, psychiatric health facility, residential treatment center or day treatment center* for the treatment of *mental or nervous disorders, severe mental disorders*, or substance abuse.

Family Member is the *plan participant's* enrolled *spouse*, or enrolled *domestic partner*, and each enrolled eligible *child*.

Federally Eligible Defined Individual is an individual who, as of the date on which the individual seeks coverage under Section 1366.35 of the California Health and Safety Code, meets all of the following conditions: (i) has had 18 or more months of *creditable coverage* and whose most recent prior *creditable coverage* was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002); (ii) is not eligible for coverage under a group health plan, *Medicare*, or Medi-Cal, and does not have other health insurance coverage; (iii) was not terminated from his or her most recent *creditable coverage* due to nonpayment of premiums or fraud; and (iv) if offered continuation coverage under *COBRA* or *CalCOBRA*, has elected and exhausted that coverage.

Formulary Drugs are brand name drugs selected by us as preferred drugs. We may add or delete drugs from the Formulary from time to time.

Generic Prescription Drug (Generic Drug) is a pharmaceutical equivalent of one or more *brand name drugs* and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the *brand name drug*.

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: (i) certified by *Medicare* as a *hospice*; (ii) recognized by *Medicare* as a hospice demonstration site; or (iii) 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*, *severe mental disorder*, or substance abuse, "hospital" also includes *psychiatric health facilities*.

Infertility is: (i) the presence of a condition recognized by a *physician* as a cause of *infertility*; or (ii) 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.

In-Network describes services or visits provided by a *COE* and by *participating providers* (but not including services or visits covered only on an *in-network* basis if provided by a *COE*).

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.

Life-Threatening means either or both of the following: diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.

Medically Necessary procedures, supplies equipment or services are those 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;
 - 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.

Medically Necessary Hospital Days are those days for which inpatient care is determined to be *medically necessary*.

Medical Plan Document and Disclosure Form is this written description of the benefits provided under the *plan*.

Medicare means those hospital benefits and other health care benefits covered under the supplemental medical insurance program of Title XVIII of the Social Security Act 42 U.S.C. §§ 1395 *et seq.*

Medicare Beneficiary means an individual enrolled in Medicare.

Member is the *plan participant* or *family member*.

Mental Or Nervous Disorders, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior, including *severe mental* disorders. 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.

Negotiated Drug Fee is the rate that the *claims administrator* has negotiated with *participating pharmacies* under a Participating Pharmacy Agreement for *prescription drug maximum allowed amount*. *Participating pharmacies* have agreed to charge *beneficiaries* no more than the *negotiated drug fee*. It is also the rate which Prescription Drug Program - Mail Service has agreed to accept as payment in full for mail service *prescription drugs*.

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 *claims administrator's* Participating Provider Agreements. With respect to *non-participating providers*, the *negotiated rate* means the typical fee *participating hospitals* and *participating physicians* agree to accept as payment in full of covered services as determined by the *claims administrator*, as appropriate, in its discretion; provided however that with respect to out-of-network emergency services, "negotiated rate" means, for a particular emergency service, the highest of (i) the negotiated rate (as defined without regard to this provision); (ii) the median amount negotiated with in-network providers by the Plan Administrator or (iii) the amount which would be paid under Medicare, all as determined pursuant to 45 CFR § 147.138 (b)(3).

Non-Eligible Physician is a *physician* who is of a specialty with which the *claims administrator*, as appropriate, does not currently enter into *claims administrator's* Participating Agreements.

Non-Emergency Admission is an admission which is not due to an *emergency*.

Non-Participating Pharmacy is a *pharmacy* which does not have a Participating Pharmacy Agreement in effect with the *claims administrator* at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a *non-participating pharmacy*.

Non-Participating Provider is one of the following providers which does NOT have a *claims administrator's* Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;

7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

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.

Non-Participating Provider Preventive Care constitutes the services described in the MEDICAL CARE THAT IS COVERED section. Certain coverage limitations and cost-sharing requirements apply. See MEDICAL BENEFITS.

Other Health Care Providers are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as *ambulance* companies. *Other health care providers* are not part of the *plan* provider network.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed *ambulance* company; or
4. A *hospice*.

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

Out-of-Network describes services or visits rendered by non-participating hospitals, non-participating physicians and other *non-participating providers*, and with respect to services or visits covered on an *in-network* basis only if provided by *COE*, services or visits provided by any Provider other than a *COE*.

Out-of-Pocket Amount is the amount for which a *member* is responsible when the *claims administrator's* allowance, as appropriate, for covered services is paid. The *member's out-of-pocket amount* does not include:

1. Any expense incurred which exceeds *covered expense* or *prescription drug maximum allowed amount*;
2. Any expense incurred because the *member* did not obtain pre-authorization, *pre-admission review* or *concurrent review* when required to do so under the heading Medical Management Program.
3. Any expense incurred because of *plan* limitations on the number of visits, days of treatment, or dollar limitations on days of treatment or other similar limitations on specific benefits;
4. Any amount for which a *member* is responsible when the maximum benefits of this *plan* are paid;

5. Any amount for which the *member* is responsible for *prescription drugs*; or
6. Any *co-payment* for covered services.

Participating Employer is a firm participating in the *plan*, where more than 50 percent of all the *participating employer's* owners (i.e., principals, proprietors, partners, shareholders or other owners) are Certified Public Accountants and all Certified Public Accountant-owners are members of *CalCPA* in good standing or a candidate applying for *CalCPA* membership. Specific qualifications of a *participating employer* are stipulated in the *subscription agreement* between the *trust* and the *participating employer*.

Participating Hospital is a *hospital* which has a *claims administrator's* Participating Agreement in effect with the *claims administrator*, as appropriate, at the time services are rendered. *Participating hospitals* agree to accept the *negotiated rate* as payment in full for covered services. *Participating hospitals* agree to participate in procedures established to review the utilization of *hospital* services. *Hospital* services determined to be unnecessary, according to these utilization review procedures, are not covered by the *plan*. A list of *participating hospitals* is available upon request from the *plan administrator*, as appropriate.

Participating Pharmacy is a *pharmacy* which has a Participating Pharmacy Agreement in effect with the *claims administrator* at the time services are rendered. Call your local *pharmacy* to determine whether it is a *participating pharmacy* or call the toll-free customer service telephone number. Many participating pharmacies display a "Rx" decal with the *claims administrator's* logo in their window so that you can easily identify them.

Participating Provider is one of the following providers which has a *claims administrator's* Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

Participating providers agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Pharmacy means a licensed retail pharmacy.

Physical Therapy, Physical Medicine and Occupational Therapy (including Chiropractic Care) means the benefits described under the heading Physical Therapy, Physical Medicine and Occupational Therapy (including Chiropractic Care).

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 booklet, 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 psychologist
 - f. A chiropractor (D.C.)
 - g. A certified registered nurse anesthetist
 - h. An acupuncturist (A.C.)
 - i. A clinical social worker (C.S.W. or L.C.S.W.)
 - j. A marriage, family and child counselor (M.F.C.C.)
 - k. A physical therapist (P.T. or R.P.T.)*
 - l. A speech pathologist*
 - m. An audiologist*
 - n. An occupational therapist (O.T.R.)*
 - o. A respiratory care practitioner (R.C.P.)*
 - p. A psychiatric mental health nurse
 - q. A Physician assistant*
 - r. A nurse midwife**
 - s. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only
 - t. A registered nurse practitioner

* **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 *Medical Plan Document and Disclosure Form* and in the amendments to this *Medical Plan Document and Disclosure Form*, 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 *Medical Plan Document and Disclosure Form* will be issued to each *plan participant* affected by the change. (The word “*plan*” here does not mean the same as “*plan*” as used in ERISA.)

Plan Administrator refers to the BOARD OF TRUSTEES OF THE GROUP INSURANCE TRUST OF THE CALIFORNIA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS, who is responsible for the administration of the *plan*.

Plan Agent is the agent of the *plan* responsible for administering enrollment, underwriting and premium collection functions. Until replaced by the *plan administrator*, the *plan agent* is Banyan Administrators, LLC.

Plan Document is this document.

Plan Participant is any person enrolled in the *plan* that meets the eligibility requirements as outlined in the *subscription agreement*.

Pre-Admission Review occurs before a proposed *hospital* admission to determine if such an admission is *medically necessary*.

Pre-Existing Condition means an illness, injury or condition which existed during the six-month period immediately prior to your *effective date*. A condition is considered to have existed when medical advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a licensed health practitioner.

Prescription means a written order or refill notice issued by a licensed prescriber.

Prescription Drug Maximum Allowed Amount does not include any expense in excess of: (i) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies*; or (ii) the *negotiated drug fee* for *drugs* dispensed by *participating pharmacies* or by the mail service program.

Preventative Care is the services described as such in “Medical Care that is Covered” section. The scope of Preventative Care is different for services provided by Participating Providers than for services provided by a Non-Participating provider.

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

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: (i) were covered under the prior plan on the date that plan terminated; (ii) properly enrolled for coverage within 31 days of this *plan’s effective date*; and (iii) 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.

Protected Health Information means information about you and your medical case, the privacy of which is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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.

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.

Qualified Beneficiary, for the purposes of *COBRA*, is any of the following who is not entitled to *Medicare* on the day before the *qualifying event* and who on the date of the *qualifying event* is covered under the *plan* pursuant to the Subscription Agreement of a *COBRA participating employer*:

1. The *plan participant*;
2. A *plan participant's spouse*;
3. A *plan participant's former spouse* (or legally separated *spouse*); or
4. A *child*, including a *child* born to or placed for adoption with the *plan participant* during the *COBRA* continuation period.

Qualified Beneficiary, for the purposes of *CalCOBRA*, is any individual who on the date of the *qualifying event* is covered under the *plan* pursuant to the Subscription Agreement of a *CalCOBRA participating employer* and is not a *CalCOBRA excluded member*. *Qualified beneficiary* also includes any *child* who is born to a former *plan participant* of a *CalCOBRA participating employer*, which *plan participant* is a *qualified beneficiary* who has elected *CalCOBRA* coverage, or a *child* who is placed for adoption with such a former *plan participant* so electing, if the *child* is enrolled in the *plan* within 30 days after the *child's* birth or placement for adoption. Such entitlement to benefits, subject to applicable terms and conditions, shall continue for the remainder of the period during which the *plan participant* is covered under *CalCOBRA*.

Qualifying Event for the purposes of *COBRA* means any one of the following events that, but for election of coverage under *COBRA* or *CalCOBRA*, would otherwise result in a loss of coverage under the *plan* to a *qualified beneficiary*:

1. The death of the *plan participant*;
2. Termination of employment or reduction in the *plan participant's* employment, except that termination for gross misconduct does not constitute a *qualifying event*;
3. The divorce or legal separation of the *plan participant* from the *plan participant's spouse*;
4. The loss of *dependent* status by a *dependent child* enrolled in the *plan*; or
5. With respect to any *qualified beneficiary* other than the *plan participant*, the *plan participant's* entitlement to benefits under *Medicare*.

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

Referral Center functions as a contact point for the *member*. The *referral center* answers questions and facilitates the Medical Management Programs provisions of the *plan*.

Residential Treatment Center is an inpatient treatment facility where the *member* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental or nervous disorder, severe mental disorder*, or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders, severe mental disorders*, or rehabilitative treatment of substance abuse according to state and local laws.

Self-Administered Injectable Drugs are injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the *beneficiary* and labeled or approved for self-administration by the Food and Drug Administration (excluding insulin).

Severe Mental Disorders include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the

home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Benefits for severe mental disorders will be provided according to the *plan's* benefits for medical conditions, and will not be subject to *plan* provisions for *mental or nervous disorders*.

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. For the purpose of care provided for the treatment of *mental or nervous disorders, severe mental disorders*, or substance abuse, the term "skilled nursing facility" includes *residential treatment center*.

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.

Sponsor means *CalCPA*.

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.

Subscription Agreement means the medical plan Subscription Agreement entered into by a *participating employer* and accepted by the *trust*.

Substance Abuse is abuse of a substance where the abuse affects thinking or the ability to figure things out, perception, mood and behavior. Treatment for *substance abuse* does not include smoking cessation programs nor treatments for nicotine dependency or tobacco use.

Totally Disabled Dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

Totally Disabled Plan Participant is a *plan participant* who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience, and who is in fact unemployed.

Trust is the Group Insurance Trust of the California Society of Certified Public Accountants.

Urgent Care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Well Baby Care means the benefits described under the heading Well Baby Care.

Well Woman Care means the benefits described under the heading Well Woman Care.

We (us, our) refers to the Group Insurance Trust of the California Society of Certified Public Accountants.

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

You (your) refers to the *plan participant* and *dependents* who are enrolled for benefits under this *plan*.

GENERAL PLAN INFORMATION

The following information, together with the preceding material, forms a *Medical Plan Document and Disclosure Form* under the Employee Retirement Income Security Act of 1974 (ERISA) and the Patient Protection and Affordable Care Act of 2010 (PPACA). The benefit plan description covers group medical coverage to eligible employees of the Group Insurance Trust of the California Society of Certified Public Accountants. The Group Insurance Trust of the California Society of Certified Public Accountants is administered on a self insured basis with benefit claims processed by Anthem Blue Cross, on behalf of Anthem Blue Cross Life & Health Insurance Company (*claims administrator*).

1. **Agent for Service of Legal Process.** The name and address of the designated agent for the service of legal process for the *plan* is the *plan administrator*.

Service of legal process may also be served upon the *plan trustee*.

2. a. **Claims Procedures.** The *plan* provides hospital and medical benefits as administered under a contract between the Group Insurance Trust of the California Society of Certified Public Accountants and Anthem Blue Cross Life & Health Insurance Company. The *plan administrator* has delegated to the *claims administrator* in the *plan documents* the complete authority to use its discretion to interpret and administer provisions of the *plan* and to act as claims fiduciary under the *plan* as set forth in ERISA. Under ERISA and PPACA the *claims administrator* must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Therefore, the hiring, compensation, termination, promotion or other similar action relating to the individuals deciding claims and appeals cannot be based on the probability of that individual to deny benefits.

The plan document and this booklet entitled “*Medical Plan Document and Disclosure Form*,” contain information on reporting claims, including the time limitations on submitting a claim and remedies available under the *plan* for the redress of *adverse benefit determinations*. Claim forms may be obtained from the *plan administrator* or from the *claims administrator*. (Note that the *claims administrator* is not the *plan administrator* nor the administrator for the purposes of ERISA.) In addition to this information, ERISA and PPACA apply some additional claims procedure rules. The additional rules required by ERISA and PPACA are set forth below.

Urgent Care. The *claims administrator* must notify you, within 24-hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24-hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48-hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 48-hours after the *claims administrator's* receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits, whichever is earlier, if the information is received within the time frame noted above. The notice will be written or electronic, or oral followed within three days by written or electronic notice, and provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) description of available internal and external review processes and how to initiate an appeal; (v) a description of any additional information or material that you can provide to perfect the claim and an explanation as to why such information or material is necessary; (vi) a description of the applicable review procedures and time limits including a statement of your rights to bring a civil action; (vii) a description of the applicable expedited review process and (viii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals. You have 180-days to appeal their *adverse benefit determination*.

You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. You may also submit written comments, documents, records and any other information related to your claim for benefits. Within 72-hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you by telephone, facsimile or other fast means. Sufficiently in advance of any final adverse determination, you must receive, free of charge, any new or additional evidence that was considered or relied upon to make such final adverse determination. [If the *claims administrator* denies your appeal, they must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) that you are entitled to copies, free of charge, of all documents related to the claim for benefits; (v) a copy or description of any internal rule or guideline used to make the adverse benefit determination; (vi) an explanation of the scientific or clinical judgment used to assess a medical necessity or experimental treatment or similar exclusion, if applicable, or that you are entitled to copies of the same free of charge; (vii) a statement of your alternative dispute resolution options such as mediation and (viii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

If your request for benefits is no longer considered urgent, it will be handled in the same manner as a *Non-Urgent Care Pre-Service* or *Post-Service* appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The *claims administrator* must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits from the time they received your initial request for benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within

5-days after they get it and tell you specifically what information is missing. You then have 45-days after receiving this notice to provide them with the information they need to process your request for benefits. The time period during which the *claims administrator* is waiting for receipt of the necessary information is not counted toward the time frame in which the *claims administrator* must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time limits stated in the previous paragraph after the *claims administrator* has all the information they need to process your request for benefits, if the information is received within such time limits noted above. The notice will be written or electronic and provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) description of available internal and external review processes and how to initiate an appeal; (v) a description of any additional information or material that you can provide to perfect the claim and an explanation as to why such information or material is necessary; (vi) a description of the applicable review procedures and time limits including a statement of your rights to bring a civil action and (vii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

You have 180-days to appeal their adverse benefit determination. Your appeal must be in writing. You may also submit written comments, documents, records and any other information related to your claim for benefits. Sufficiently in advance of any final adverse determination, you must receive, free of charge, any new or additional evidence and/or rationale that was considered or relied upon to make such final adverse determination. Within 30-days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing. If the *claims administrator* denies your appeal, they must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) that you are entitled to copies, free of charge, of all documents related to the claim for benefits; (v) a copy or description of any internal rule or guideline used to make the adverse benefit determination; (vi) an explanation of the scientific or clinical judgment used to assess a medical necessity or experimental treatment or similar exclusion, if applicable, or that you are entitled to copies of the same free of charge; (vii) a statement of your alternative dispute resolution options such as mediation and (viii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

Concurrent Care Decisions.

- i. **Reduction or Termination of Benefits.** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved the *claims administrator* decides to reduce or end the benefits they have approved for you, in whole or in part:

They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their written or electronic notice to you, the *claims*

administrator must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) description of available internal and external review processes and how to initiate an appeal; (v) a description of any additional information or material that you can provide to perfect the claim and an explanation as to why such information or material is necessary; (vi) a description of the applicable review procedures and time limits including a statement of your rights to bring a civil action and (vii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals. .

To keep the benefits you already have approved, you must successfully appeal the *claims administrator's* decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an *urgent care* denial of benefits (see the section "Urgent Care" above), depending upon the circumstances of your condition.

If the *claims administrator* receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If the *claims administrator* denies your appeal, they must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) that you are entitled to copies, free of charge, of all documents related to the claim for benefits; (v) a copy or description of any internal rule or guideline used to make the adverse benefit determination; (vi) an explanation of the scientific or clinical judgment used to assess a medical necessity or experimental treatment or similar exclusion, if applicable, or that you are entitled to copies of the same free of charge; (vii) a statement of your alternative dispute resolution options such as mediation and (viii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

You may further appeal the denial of benefits according to the rules for appeal of an *urgent care* denial of benefits (see the section "Urgent Care" above).

- ii. **Extension of Benefits.** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

You must make a request to the *claims administrator* for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an *Urgent* or *Non-Urgent Care Pre-Service* request for benefits.

If the *claims administrator* receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If the *claims administrator* denies your request for additional benefits, in whole or in part, their written or electronic notice to you must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) description of available internal and external review processes and how to initiate an appeal; (v) a description of any additional information or material that you can provide to perfect the claim and an explanation as to why such information or material is necessary; (vi) a description of the applicable review procedures and time limits including a statement of your rights to bring a civil action and (vii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

You may appeal the *adverse benefit determination* according to the rules described in this claims procedure section for appeal for *Urgent, Pre-Service* or *Post-Service adverse benefit determinations*, depending upon the circumstances. If the *claims administrator* denies your appeal, whether *Urgent, Pre-Service* or *Post-Service*, they must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) you that you are entitled to copies, free of charge, of all documents related to the claim for benefits; (v) a copy or description of any internal rule or guideline used to make the adverse benefit determination; (vi) an explanation of the scientific or clinical judgment used to assess a medical necessity or experimental treatment or similar exclusion, if applicable, or that you are entitled to copies of the same free of charge; (vii) a statement of your alternative dispute resolution options such as mediation and (viii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

Non-Urgent Care Post-Service (reimbursement for cost of medical care). The *claims administrator* must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits from their receipt of your initial request. If you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they get it and tell you what information is missing. You then have 45-days to provide them with the information they need to process your claim. The time period during which the *claims administrator* is waiting for receipt of the necessary information is not counted toward the time frame in which the *claims administrator* must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time limits stated in the previous paragraph, or after the

claims administrator has all the information they need to process your claim, if the information is received within the time limits noted above. The notice will be written or electronic and provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) description of available internal and external review processes and how to initiate an appeal; (v) a description of any additional information or material that you can provide to perfect the claim and an explanation as to why such information or material is necessary; (vi) a description of the applicable review procedures and time limits including a statement of your rights to bring a civil action and (vii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

You have 180-days to appeal their decision. Your appeal must be in writing. Within 60-days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing. If the *claims administrator* denies your appeal, they must provide the following information: (i) specific information to identify the claim involved; (ii) the specific reason or reasons for the *adverse benefit determination*; (iii) the specific plan provisions upon which the denial decision was based; (iv) that you are entitled to copies, free of charge, of all documents related to the claim for benefits; (v) a copy or description of any internal rule or guideline used to make the adverse benefit determination; (vi) an explanation of the scientific or clinical judgment used to assess a medical necessity or experimental treatment or similar exclusion, if applicable, or that you are entitled to copies of the same free of charge; (vii) a statement of your alternative dispute resolution options such as mediation and (viii) the contact information for the health insurance consumer assistance office that can assist with the internal and external claims procedures and appeals.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the *claims administrator* and request a review of the denial. In connection with such a request:

- 1) Documents pertinent to the administration of the *plan* may be reviewed free of charge; and
- 2) Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “*Urgent Care*,” “*Non-Urgent Care Pre-Service*,” and “*Non-Urgent Care Post-Service*,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

A claim involving *urgent care* is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care”

under this definition must be treated as an urgent care claim by the *plan*. Absent a determination by the claimant's physician, the determination of whether a claim involves urgent care is to be made by an individual acting on behalf of the *plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

A *pre-service* claim is any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Post-service claims are health care claims that are not *urgent care* or *pre-service* claims.

- b. **Enforce Your Rights Under ERISA.** There are steps *you* can take to enforce your rights under the *plan*. If you have a claim for benefits which is denied, in whole or in part, after all mandatory reviews have been completed, you may file suit in a state or federal court. In addition, you may also have other voluntary alternative dispute resolution options, such as mediation or arbitration as provided in the *plan* booklet. One way to find out what may be available is to contact the local office of the U.S. Department of Labor or applicable State regulatory agency.

If the *claims administrator* fails to strictly follow all the internal claims procedures and requirements described in section 2.a. above, for example the various time limits related to notifying you of a decision, then you are deemed to have completed all mandatory internal claims and appeals procedures, regardless of whether the *claims administrator* substantially complied with such requirements, or any error was insignificant. In this case, you may immediately initiate the external review process or pursue any remedies under Section 502(a) ERISA or state law, as applicable, on the basis that the *claims administrator* failed to provide reasonable internal claims and appeals processes that would provide a decision on the merits of the claim. If you choose to pursue remedies under Section 502(a) of ERISA, your claim or appeal is deemed denied on review without the discretion of the appropriate fiduciary.

- c. **ERISA Claim Appeals (Internal Procedures).** The review conducted of an appeal from an *adverse benefit determination* shall not afford deference to the initial adverse determination and shall not be conducted by the individual or a subordinate of the individual who made the adverse determination that is the subject of the appeal. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not *medically necessary* or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In any case where medical or vocational experts are consulted in connection with the review of an appeal, the decision shall identify the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Each such medical or vocational expert shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.
- d. **An Authorized Representative May Act On Behalf Of The Claimant.** An authorized representative of a claimant may act on behalf of a claimant in pursuing a benefit claim or

appeal of an adverse benefit determination. For procedures regarding how to become an authorized representative, please contact the *claims administrator*. Notwithstanding the foregoing, in the case of a claim involving *urgent care*, a physician with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

- e. **Non-Urgent Care Pre-Service (when claim not properly submitted).** In the case of failure by a claimant or an authorized representative of a claimant to follow the *plan's* procedures for filing a *pre-service* claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of a failure to file a claim involving *urgent care*) following the failure. Notification may be oral unless written notification is requested by the claimant or authorized representatives. The notification described above with respect to failure to follow procedures on *pre-service* claims shall apply only in the case of a failure that: (i) is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and (ii) is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.
- f. **Arbitration.** Sometimes disputes or disagreements may arise between the *beneficiary* (including enrolled *family member*, heirs or personal representatives) and *claims administrator* regarding the construction, interpretation, performance or breach of the applicable *Medical Plan Document and Disclosure Form*, or regarding other matters relating to or arising out of membership in this *plan*. Typically such disputes are handled and resolved through the *claims administrator's* Grievance and Appeal process described above. However, in the event that a dispute is not resolved in that process, *claims administrator* uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with *claims administrator* involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

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.

As a condition to becoming a *beneficiary*, you agree to submit all disputes you may have with *claims administrator* to final and binding arbitration, except as described in the penultimate paragraph of this section or otherwise provided herein. Likewise, *claims administrator* agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both the *beneficiary* and *claims administrator* are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by *claims administrator's* binding arbitration process.

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Claims administrator's binding arbitration process is 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*.

Arbitration can be initiated by submitting a demand for arbitration to *claims administrator* at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Anthem Blue Cross Life & Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Medical Plan Document and Disclosure Form*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be binding on all parties. The parties will share equally the arbitrator's fee involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Beneficiaries are *not* required to submit disputes about certain *adverse benefit determinations* made by *claims administrator* to mandatory binding arbitration. Under ERISA, an *adverse benefit determination* means a decision by *claims administrator* to deny, reduce, terminate or not pay for all or a part of a benefit. However, the *beneficiary* and *claims administrator* may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises. As arbitration is a voluntary dispute resolution method, it does not constitute a required part of the claims procedure and may be omitted without any affect of your rights in court.

For the purposes of this provision, the meanings of the terms "urgent care," "Non-Urgent Care Pre-Service," and "Non-Urgent Care Post-Service," used in this provision, have the meanings set forth by ERISA for a "claim involving urgent care," "pre-service claim," and "post-service claim," respectively.

- g. **Civil Actions under ERISA.** *Members* who are enrolled in ERISA plans have the right to file a civil action under Section 502(a) of ERISA if a claim for benefits has not been approved after all mandatory reviews as outlined above have been completed. The *member* may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or applicable State insurance regulatory agency.

The review conducted of an appeal from an adverse benefit determination shall not afford deference to the initial adverse determination and shall not be conducted by the individual or a subordinate of the individual who made the adverse determination that is the subject of the appeal. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not *medically necessary* or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In any case where medical or vocational experts are consulted in connection with the review of an appeal, the decision shall identify the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Each such medical or vocational expert shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

An authorized representative of a claimant may act on behalf of a claimant in pursuing a benefit claim or appeal of an adverse benefit determination. For procedures regarding how to become an authorized representative, please contact the *claims administrator*. Notwithstanding the foregoing, in the case of a claim involving urgent care, a physician with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

In the case of failure by a claimant or an authorized representative of a claimant to follow the *plan's* procedures for filing a pre-service claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral unless written notification is requested by the claimant or authorized representatives. The notification described above with respect to failure to follow procedures on pre-service claims shall apply only in the case of a failure that: (i) is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and (ii) is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

h. **Review of Denials of Experimental or Investigative Treatment.** If coverage for a proposed treatment is denied because the *claims administrator* determines that the treatment is *experimental* or *investigative*, the *member* may ask that the denial be reviewed by an external independent medical review organization with which the *claims administrator* contracts. To request this review, the *member* should call the *claims administrator* at the address shown under the Notice of Claim section. To receive this review, all of the following conditions must be met:

1. The *member* must have a *life-threatening* condition or a seriously debilitating condition.
2. The *member's physician* certifies that the *member* has a condition for which standard therapies have not been effective in improving the condition of the *member*, for which

standard therapies would not be medically appropriate for the *member*, or for which there is no more beneficial standard therapy covered by the *plan* than the therapy proposed pursuant to paragraph 3 below.

3. Either:
 - a. The *member's physician* has recommended a drug, device, procedure, or other therapy that the *physician* certifies in writing is likely to be more beneficial to the *member* than any available standard therapies; or
 - b. The member, or the member's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's condition, has certified to or requested a therapy that, based on two documents from the medical and scientific evidence, as defined below, is likely to be more beneficial for the member than any available standard therapy.

The *physician's* certification shall include a statement describing the evidence relied upon by the *physician* in certifying his or her recommendation. The *plan* shall not be required to pay for the services of a *non-participating provider* that are not otherwise covered pursuant to the contract.

4. The *member* has been denied coverage by the *claims administrator* for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph 3, unless coverage for the specific therapy is excluded by the *Medical Plan Document and Disclosure Form*.
5. The specific drug, device, procedure, or other therapy recommended by the *physician* for the *member* pursuant to paragraph 3 would be a covered service except for the *claims administrator's* determination that the therapy is experimental or under investigation.

The *plan* shall offer all *members* who meet the above criteria the opportunity to have the requested therapy reviewed under the external independent review process. The *plan* shall notify the *member* of this opportunity within five business days after the decision to deny coverage.

If this review is requested either by a *member* or by a *physician*, the requestor must supply two items of acceptable medical and scientific evidence. This evidence should be obtained from one or more of the following sources:

6. Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
7. Medical literature meeting a criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
8. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
9. The American Hospital Formulary Service-Drug Information, the American Medical

Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug information;

10. Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

11. Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five days of receiving a request for review, the *claims administrator* will send the reviewing panel all relevant medical records and documents in its possession, as well as any additional information submitted by the *member* or by his or her *physician*. Information the *claims administrator* receives subsequently will be sent to the review panel within five business days of its receipt. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of a request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

- i. **Independent Medical Review of Grievances Involving a Disputed Health Care Service.** A *member* may request an independent medical review (“IMR”) of disputed health care services from the California Department of Insurance if he or she believes that the *plan* has improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the *member’s* coverage that has been denied, modified, or delayed by the *plan*, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The *member* has the right to provide information in support of the request for an IMR. The *plan* must provide the *member* with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a *member* to forfeit any California statutory right to pursue legal action against the *plan* regarding the disputed health care service. It should be noted that the *plan* does not believe any such California statutory right exists which is applicable to it. For more information regarding the IMR process, or to request an application form, please call the *plan agent*.

Eligibility. The California Department of Insurance will review the *member’s* application for an IMR to confirm that:

1. a. The provider has recommended a health care service as *medically necessary*.
 - b. The *member* has received *urgent care* or *emergency services* that a provider determined was *medically necessary*; or
 - c. The member has been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which he or she seeks independent review.
2. The disputed health care service has been denied, modified, or delayed by the *claims administrator* based in whole or in part on a decision that the health care service is not *medically necessary*; and

3. The *member* filed a grievance with the *plan agent* and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the *member* may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the *member* follow the *plan's* grievance process in extraordinary and compelling cases.

If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is *medically necessary*. The *member* will receive a copy of the assessment made. If the IMR determines the service is *medically necessary*, the *plan* will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the California Department of Insurance must provide its determination within 30 days of receipt of the *member's* application and supporting documents. For urgent cases involving an imminent and serious threat to a *member's* health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the *member's* health, the IMR organization must provide its determination within three business days.

3. **Description of Benefits.** The *Medical Plan Document and Disclosure Form* sets forth the benefits, deductibles, co-payments, co-insurance, benefit maximums, limitations and exclusions, and the extent to which preventive care is provided under the *plan*. An explanation of the benefits, co-payments, co-insurance, benefit maximums, limitations and exclusions and the extent to which preventive care is covered, may be found in the sections entitled TYPES OF PROVIDERS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS (including the subsections HOW COVERED EXPENSE IS DETERMINED, DEDUCTIBLES, CO-INSURANCE/CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, and MEDICAL CARE THAT IS NOT COVERED), PRE-EXISTING CONDITION EXCLUSION, REIMBURSEMENT FOR ACTS OF THIRD PARTIES, YOUR PRESCRIPTION DRUGS BENEFITS, MEDICAL MANAGEMENT PROGRAMS (including the subsections UTILIZATION REVIEW PROGRAM, AUTHORIZATION PROGRAM, THE MEDICAL NECESSITY REVIEW PROCESS, PERSONAL CASE MANAGEMENT, DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS, and QUALITY ASSURANCE), COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES, EXTENSION OF BENEFITS, GENERAL PROVISIONS, and DEFINITIONS. Information about prescription drug benefits, deductibles, co-payments, benefit maximums, limitations and exclusions, including what drugs are covered under the *plan*, and how it is decided what drugs the plan will cover, is provided in the section YOUR PRESCRIPTION DRUG BENEFITS (including the subsections PRESCRIPTION DRUG MAXIMUM ALLOWED AMOUNT, PRESCRIPTION DRUG DEDUCTIBLE AND CO-PAYMENTS, PRESCRIPTION DRUG UTILIZATION REVIEW, PREFERRED DRUG PROGRAM, PRESCRIPTION DRUG CONDITIONS OF SERVICE, PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED and PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED).

Statement of Rights Under the Women’s Cancer Rights Act of 1998. Did you know that your *plan*, as required by the Women’s Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema)? Call your *plan agent* for more information.

Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”). If you or your *spouse* are required, due to a QMCSO, to provide coverage for your *child(ren)*, you may ask your employer or *plan agent* to provide you, without charge, a written statement outlining the procedures for getting coverage for such *child(ren)*.

4. **Eligibility for Participation.** The eligibility requirements for participation under the *plan* are set forth in the *Medical Plan Document and Disclosure Form* in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.
5. **Grounds for Ineligibility or Loss or Denial of Benefits.** Details describing the circumstances which may result in: (i) disqualification from the *plan*; (ii) ineligibility for benefits; or (iii) denial, loss, forfeiture or suspension of benefits under the *plan* are set forth and identified in the *Medical Plan Document and Disclosure Form*, as outlined below:
 - a. Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.
 - b. Benefits may be denied or suspended if statements a *plan participant* has made in connection with obtaining coverage were false.
 - c. Information concerning situations under which benefits may be reduced or denied may also be found in the sections entitled TYPES OF PROVIDERS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS (including the subsections HOW COVERED EXPENSE IS DETERMINED, DEDUCTIBLES, CO-INSURANCE/CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, and MEDICAL CARE THAT IS NOT COVERED), PRE-EXISTING CONDITION EXCLUSION, REIMBURSEMENT FOR ACTS OF THIRD PARTIES, YOUR PRESCRIPTION DRUGS BENEFITS, MEDICAL MANAGEMENT PROGRAMS (including the subsections UTILIZATION REVIEW PROGRAM, AUTHORIZATION PROGRAM, THE MEDICAL NECESSITY REVIEW PROCESS, PERSONAL CASE MANAGEMENT, and QUALITY ASSURANCE), COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES EXTENSION OF BENEFITS, GENERAL PROVISIONS, and DEFINITIONS. Information about prescription drug benefits, deductibles, *co-payments*, benefit maximums, limitations and exclusions, including what drugs are covered under the *plan*, and how it is decided what drugs the *plan* will cover, is provided in the section YOUR PRESCRIPTION DRUG BENEFITS (including the subsections PRESCRIPTION DRUG MAXIMUM ALLOWED AMOUNT, PRESCRIPTION DRUG DEDUCTIBLE AND CO-PAYMENTS, PRESCRIPTION DRUG UTILIZATION REVIEW, PREFERRED DRUG PROGRAM, PRESCRIPTION DRUG CONDITIONS OF SERVICE, PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED and PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED).
6. **Plan Administrator.** The name and address of the *plan administrator* is:

The Board of Trustees of the Group Insurance Trust of the
California Society of Certified Public Accountants
1800 Gateway Drive, Suite 201
Redwood City, California 94065

7. **Plan Name.** The designated name of the Plan is: Group Insurance Trust of the California Society of Certified Public Accountants.

8. **Plan Numbers.**

The Sponsor's Identification Number (EIN) is 94-1056137.

The Plan Number is 501.

9. **Plan Sponsor.** The name and address of the entity which established and maintains the *plan* is:

California Society of Certified Public Accountants (*CalCPA*)
1800 Gateway Drive, Suite 200
San Mateo, California 94404

The *plan* is also maintained by *participating employers*.

More complete information on all Plan Sponsors is available, as specified under ERISA, from the Plan Trustees

10. **Plan Trustee.** The name and business address of the Plan Trustee is:

The Board of Trustees of the Group Insurance Trust of the
California Society of Certified Public Accountants
1800 Gateway Drive, Suite 201
San Mateo, California 94404

11. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on January 1st and ending on the following December 31st.

12. **Source of Plan Contributions.** The contributions necessary to finance the *plan* are provided through contributions required for participation in the *plan* and through other assets of the *trust*.

13. **Type of Administration/Funding.** Benefits are furnished under a health care plan funded by the *participating employers*. Anthem Blue Cross Life furnishes only certain claim processing and provider contracting services and has no financial responsibility for benefits.

Anthem Blue Cross Life is the Administrator but not the "Plan Administrator" as defined or described by either the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time. Anthem Blue Cross Life acknowledges that it is a claim fiduciary for ERISA purposes.

14. **Type of Plan.** The Plan is an employee welfare benefit plan providing group medical benefits.

FOR YOUR INFORMATION

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or *family member*.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver license or identification card.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

NOTICE

1. The Multiple Employer Welfare Arrangement (MEWA) is not an insurance company and does not participate in any of the guarantee funds created by California Law. Therefore, these funds will not pay a beneficiary's claims or protect his or her assets if a MEWA becomes insolvent and is unable to make payments as promised.
2. The health care benefits that a *member* has purchased or is applying to purchase are being issued by a MEWA that is licensed by the State of California.
3. For additional information about MEWA, questions may be directed to your *plan administrator* or *members* may contact the California Department of Insurance at (800) 927-HELP.

CLAIM FIDUCIARY

The Plan provides hospital and medical benefits as administered under a contract between the Group Insurance Trust of the California Society of Certified Public Accountants and Anthem Blue Cross Life & Health Insurance Company. The Plan has delegated to Anthem Blue Cross Life & Health Insurance in the Plan Documents the complete authority to use its discretion to interpret and administer provisions of the Plan and to act as claim appeal fiduciary under the Plan as set forth in ERISA.

LIST OF PARTICIPATING PROVIDERS

Any *beneficiary* may obtain a list of *participating providers* by contacting Anthem Blue Cross Customer Service for ProtectPlus Members at 1-888-209-7847 or by visiting the *trust* website at www.cpaprotectplus.com.

STATEMENT OF ERISA RIGHTS

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all *plan participants* shall be entitled to:

Receive Information About Your Plan and Benefits.

1. Examine, without charge, at the *plan administrator's* office and at other locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and *updated Medical Plan Document and Disclosure Form*. The *plan administrator* may make a reasonable charge for the copies;
3. Receive a summary of the Plan's annual financial report; the *plan administrator* is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage.

1. Continue health care coverage for yourself, *spouse* or *dependents* if there is a loss of coverage under the plan as a result of a *qualifying event*. You or your *dependents* may have to pay for such coverage. Review this *Medical Plan Document and Disclosure Form* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for *pre-existing conditions* under your group health plan, if you have *creditable coverage* from another plan.

You should be provided a certificate of *creditable coverage*, free of charge, from your group health plan or health insurance issuer when you lose coverage under the *plan*, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, you may be subject to a *pre-existing condition* exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for *plan participants*, ERISA imposes duties upon the people who are responsible for the operation of your benefit Plan. The people who operate your *plan*, called "fiduciaries" of the *plan*, have a duty to do so prudently and in the interest of you and other *plan participants* and *beneficiaries*.

No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the *plan administrator* to provide the materials requested and to pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, except that, any dispute concerning denial or partial denial of a claim must be resolved by binding arbitration as provided in the Plan booklet, unless otherwise prohibited under any applicable state or federal law. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are unsuccessful, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, you should contact the *plan agent*. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the *plan agent*, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

RATES AND BENEFITS MAY BE CHANGED AT ANY TIME UPON 60 DAYS PRIOR WRITTEN NOTICE BY THE TRUST. PAYMENT OF PREMIUM AFTER SUCH NOTICE CONSTITUTES ACCEPTANCE OF SUCH CHANGES.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Trust will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Trust will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Trust to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Trust.

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Trust, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administrative activities of the Trust, including, but not limited to:
 - (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
8. Resolution of internal grievances; and
9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The Trust Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Trust will disclose PHI to any relevant plan or insurer, including pension plans, disability plans, reciprocal benefit plans, workers' compensation insurers, etc.

For Purposes of this Section, each Participating Employer is the Plan Sponsor

The Trust will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Subscription Agreement to which it is a party has been amended to incorporate the following provisions.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Trust agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. Report to the Trust any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to an individual in accordance with HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Trust available to the HHS Secretary for the purposes of determining the Trust's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the Trust that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Adequate Separation Between the Trust and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The benefits manager; and
2. Staff designated by the benefits manager.

Limitations of PHI Access and Disclosure

The persons described in the previous section may only have access to and use and disclose PHI for Trust administration functions that the Plan Supervisor performs for the Trust.

Noncompliance Issues

If the persons described in the above section do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.