MASTER PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

EAST SIDE SELF-FUNDED PPO PLAN

Medical Claims Administrator:

Prescription Drug Claims Administrator:

Effective Date: July 1, 2017

TABLE OF CONTENTS

INTRODUCTION 1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 3
SCHEDULE OF BENEFITS 13
COST MANAGEMENT SERVICES 14
COMPREHENSIVE MEDICAL BENEFITS 28
MEDICAL/SURGICAL SERVICES AND SUPPLIES 29
DEFINED TERMS 43
PLAN EXCLUSIONS 51
PRESCRIPTION DRUG BENEFITS 57
HOW TO SUBMIT A CLAIM 60
COORDINATION OF BENEFITS 69
MEDICARE 72
THIRD PARTY RECOVERY PROVISION 73
CONTINUATION COVERAGE RIGHTS UNDER COBRA 76
RESPONSIBILITIES FOR PLAN ADMINISTRATION 83
GENERAL PLAN INFORMATION 85

INTRODUCTION

This document is a description of East Side Self-Funded PPO Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

In the event of any conflict between the provisions of the Plan as contained within the Plan Document and as set forth in any applicable collective bargaining agreement, the terms and conditions of the collective bargaining agreement will govern. In the event of any conflict between this Plan and any written instruments other than applicable collective bargaining agreements, the terms and conditions of the Plan Document will govern.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions and eligibility.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable state law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as an In-Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, Medical Necessity, failure to timely file claims, or lack of coverage.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began. An expense for a service or supply is Incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges Incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for covered Employees, Retirees and their covered Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning. If a word or phrase has a specific meaning, it starts with a capital letter and is either defined in the Defined Terms section or in the text of this document where it occurs.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

The content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The Employer's Human Resources Department can provide details concerning your specific eligibility requirements for Plan enrollment.

Eligible Classes of Employees. All Eligible Active Employees and Eligible Retired Employees of the Employer.

The following are Classes of Eligible Employees:

Certificated Employees (including certificated teachers represented by San Jose Federation of Teachers):

(1) is a certificated Full-Time Employee, subject to the collective bargaining agreement between your Employer and East Side Teachers Association/CTA/NEA. The Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) is a certificated Part-Time Employee of the Employer, subject to the collective bargaining agreement between the Employer and East Side Teachers Association/CTA/NEA. The Employee is considered to be Part-Time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work.

(3) is a Retired certificated Employee of the group and you:

- **(a)** have completed 20 years of service with the group;
- **(b)** are at least 55 years of age on the date of retirement;
- **(c)** are eligible to receive health plan benefits as part of the collective bargaining agreement; and
- **(d)** were covered under a group-sponsored health plan just before retirement.

Classified Employees:

(1) is a classified Full-Time, Active Employee of the Employer (subject to the collective bargaining agreement between the Employer and California School Employees Association East Foothills Chapter # 187). An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) is a classified Part-Time, Active Employee of the Employer (subject to the collective bargaining agreement between the Employer and California School Employees Association East Foothills Chapter # 187). An Employee is considered to be Part-Time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work.

(3) is a Retired classified Employee of the Employer and you:

- **(a)** have completed 20 years of service with the Employer;
- **(b)** are at least 55 years of age on the date of retirement;
- **(c)** are eligible to receive health plan benefits as part of the collective bargaining agreement; and
- **(d)** were covered under a group-sponsored health plan just before you retired.

All Other Employees:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) is a Part-Time, Active Employee of the Employer. An Employee is considered to be Part-Time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work.

(3) is a Retired Employee of the Employer and you:

- **(a)** have completed 20 years of service with the Employer;
- **(b)** are at least 55 years of age on the date of retirement;
- **(c)** are eligible to receive health plan benefits as part of the collective bargaining agreement; and
- **(d)** were covered under a group-sponsored health plan just before you retired.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage on the first day of the month after he or she is hired. If the hire date is the first of the month, eligibility begins that date. And the following criteria must be met:

For Plan Years beginning on or after January 1, 2015 an Employee's status as a full time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period or the monthly measurement period, as applicable, as established by the Plan in accordance with applicable law. If the look back measurement method is utilized, the Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Employer in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.)

Persons not Eligible for Benefits. Persons in the following categories are not eligible for Plan enrollment or coverage under the Plan.

(1) Any terminated Employee.

(2) Persons providing services to the Employer through a temporary agency or employer leasing organization.

(3) An independent contractor providing services to the Employer.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) **A covered Employee's Spouse.** The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state or other jurisdiction where the covered Employee lives or was married including legally separated Spouses, but shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the state or other jurisdiction in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) **A covered Employee's Child(ren).** An Employee's "Child" includes his natural Child, stepchild, Legal Guardianship, adopted Child, or a child placed with a covered Employee in anticipation of adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption

and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(3) **A covered Dependent Child who reaches the limiting age and is Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Employee must notify the Employer at least 90 days prior to the date the Child is to reach the limiting age and the Employee must send proof of the Child's physical or mental condition within 60 days of the date of receipt for request for proof. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the Child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) **A covered Employee's Domestic Partner.** Your Domestic Partner is allowed if you are Registered Domestic Partners or a domestic partner is defined as (the Employee and their Domestic Partner):

(a) Have an intimate, committed relationship of mutual caring;

(b) Live together*; and

(c) Agree to be responsible for each other's basic living expenses** during their Domestic Partnership; they also agree that anyone who is owed these expenses can collect from either of them;

(d) Are both 18 years of age or older; and

(e) Neither of you is married;

(f) Neither of you is related to the other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild;

(g) Neither of you has a different current Domestic Partner; and

(h) Neither of you has had a different Domestic Partner in the last six months (this condition does not apply if either had a partner who died).

* Live together means the Employee and the Domestic Partner share a place to live. They do not have to be on the rental agreement or deed. One or both may have a separate place somewhere else. Even if one of them leaves the place they share, they still live together as long as the one who left intends to return.
**Basic living expense means the cost of basic food and shelter. It also includes any other expenses which is paid by a benefit that the Employee or Domestic Partner gets because of the partnership.

Individuals who apply for Domestic Partner dependent coverage, are encouraged to consult with a tax attorney or accountant concerning the implications of seeking coverage in the Plan. As Domestic

Partners are not usually recognized as dependents by taxing authorities, providing coverage to a Domestic Partner could result in additional tax liability. The Employer could be required to report the fair market value of the coverage as income on an Active Employee's W-2 form.

Any false or misleading statements made by the Enrollee in order to receive benefits for which they do not qualify will subject the Enrollee to financial responsibility for any benefits paid on behalf of the Domestic Partner and potential disciplinary action by the Employer.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records (if applicable) or initiation of legal proceedings severing parental rights.

Covered Persons must live in the United States to be covered by the Plan.

These persons are excluded as Dependents:

(1) other individuals living in the covered Employee's/Retiree's home, but who are not eligible as defined;

(2) the divorced former Spouse of the Employee/Retiree;

(3) a foster child who is eligible for benefits provided by any governmental program or law;

(4) any person who is on active duty in any military service of any country;

(5) any former Domestic Partner of the Employee/Retiree;

(6) Dependents who do not live in the United States; or

(7) any person who is covered under the Plan as an Employee/Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If a person covered under this Plan changes status from Active Employee/Dependent to Retired Employee/Dependent, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums of the Retiree Plan.

If both parents are Employees, their eligible Dependent Children can be covered as the Dependents of both parents.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Domestic Partner, or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Failure to report enrollment changes could result in mispayment of Plan benefits. Should this happen, you may be required to reimburse the full amount of any benefit overpayment.

FUNDING

Cost of the Plan. The Employer may share the cost of Employee and Dependent coverage under this Plan with the covered Employees, as per the agreement with the negotiated Collective Bargaining Agreement. The enrollment application for coverage may include a payroll deduction authorization. This authorization should be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions as per the agreement with the negotiated Collective Bargaining Agreement.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for Employee-only or Dependent coverage (for example, individual, family, employee + 1) by filling out and signing an enrollment application along with the appropriate payroll deduction authorization, if applicable.

The covered Employee is required to enroll each Dependent for coverage also, except if the covered Employee already has Dependent coverage, separate enrollment for a newborn Child is required.

Enrollment Requirements for Newborn Children. A newborn Child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn Child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment", there will be no payment from the plan and the parents will be responsible for all costs. If a child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (Spouses or Domestic Partners) are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on July 1.

OPEN ENROLLMENT

Every month of May, the annual open enrollment period, eligible Employees and their eligible Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective first day of the following Plan Year and remain in effect until the next first day of the following Plan Year unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer

SPECIAL ENROLLMENT PERIODS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining

enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below.

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Losing Other Coverage May Create a Special Enrollment Right.** An Employee or Dependent that is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was under COBRA and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage and the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the Plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) **Acquiring a Newly Eligible Dependent May Create a Special Enrollment Right**. If:

(a) The Employee is a participant under this Plan, and

(b) A person becomes a Dependent of the Employee through marriage, registration of Domestic Partnership, birth, adoption or placement for adoption, or through court-ordered coverage (QMSCO),

then the Dependent may be enrolled under this Plan. If the employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a Child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 30 days that begins after the date of the marriage, birth, registration of Domestic Partnership, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage/Domestic Partnership, not later than the first day of the first month beginning after the date of the completed request for enrollment is received or in the case of Domestic Partner relationship, on the date of registration of the Domestic Partner relationship;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) **Eligibility Changes in Medicaid or State Child Health Insurance Programs May Create a Special Enrollment Right.** An Employee or Dependent who is eligible for, but not enrolled in this Plan, may also enroll in this Plan when.

(a) the Employee or Dependent loses eligibility under Medicaid or the state’s Children's Health Insurance Program (CHIP), and the Employee requests coverage under this Plan within a Special Enrollment Period of 60 days after the date of termination of coverage; or

(b) the Employee or Dependent becomes eligible for premium assistance under Medicaid or the state’s Children's Health Insurance Program (CHIP) to subsidize the cost of coverage in this Plan, and the Employee requests coverage under this Plan within a Special Enrollment Period of 60 days after eligibility for a premium assistance subsidy is determined.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met, the Employee is covered under the Plan, and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The end of the month the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, as well as any applicable state paid family leave law.

During any leave taken under the Family and Medical Leave Act or state paid family leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave or state paid family leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the applicable leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Continuation During a California Family Rights Act (CRFA) Leave. If the Employer approves the CRFA Leave, coverage under the Plan will continue during the leave. The Employee may be eligible for a CFA Leave to attend to any of the following:

- the birth or adoption of a Child; or

- placement of a Child in your custody for foster care; or
- to care for your Spouse, child, or parent with a serious health condition; or
- your serious Illness that makes you unable to perform functions of your job. For the purpose of leave provided under CFRA, your own serious Illness will not include Pregnancy or medical conditions related to Pregnancy or childbirth.

Contributions must be paid by the Employee and the Employer. If contributions are not paid, coverage will cease. However, on the date you return to work, coverage will be on the same basis as that provided for any active Employee on that date. If you have questions about this, see the Plan Administrator.

If you also eligible to continue coverage under the federal FMLA law (above), then the continuation of coverage periods under the federal FMLA and CFRA will run concurrently.

Pregnancy Disability Leave. If the Employee:

- are employed in California; and
- are a female Employee who is unable to work due to childbirth, Pregnancy, or related medical conditions;

then you may be eligible for disability leave under California Government Code Section 12945.

If the Employee is eligible for leave under California Government Code Section 12945, coverage under the Plan will continue during your leave. Contributions must be paid by the Employee and the Employer.

For more information about disability leave under California Government Code Section 12945, please see your Plan Administrator for details.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, to the extent permitted by applicable law; or as determined by the Plan Administrator.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person and the person’s covered Dependents under such an election shall be the lesser of:

  (a) The 24-month period beginning on the date on which the person's absence begins; or

  (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health Plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The end of the month that the Employee's coverage under the Plan terminates for any reason including death. (See Continuation Coverage Rights under COBRA.)

(3) The end of the month a covered Spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)

(4) The last day of the month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

EXTENSION OF COVERAGE

Unless otherwise provided in the Plan, termination of Covered Person's coverage automatically terminates coverage for the Covered Person's Dependents. If a bed patient is eligible for Hospital or Skilled Nursing Facility/Rehabilitation Facility benefits at the time coverage terminates, benefits will be paid until the earliest of:

(1) the bed patient is discharged, or

(2) care is no longer required, or

(3) the maximum Plan benefits have been exhausted.

If coverage terminates because the Covered Person is no longer in an eligible class, Continuation Coverage Rights under COBRA may be available.

SCHEDULE OF BENEFITS

Verification of Eligibility 1.844.344.8320

Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Plan is a plan which contains a Network Provider Organization.

PPO name: Anthem Blue Cross of California
Telephone: 1.866.837.4595
Web: www.anthem.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. The Plan agrees to reimburse the Provider directly for covered services.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the In-Network benefit will be made for certain Out-of-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the Network service area, the Plan will utilize the Provider's charge as the Allowed Charge.

If a Covered Person is out of the Network service area and has a Medical Emergency requiring immediate care, the Plan will utilize the Provider's charge as the Allowed Charge.

If services are performed at an In-Network Hospital or facility (including a surgeon's or Physician's office), then the Out-of-Network radiologists or pathologists performing duties at that Hospital or facility will also be treated as In-Network, the Plan will utilize the Provider's charge as the Allowed Charge.

If a Covered Person receives anesthesia services by an Out-of-Network Provider at an In-Network facility and by an In-Network surgeon, the Plan will utilize the Provider's charge as the Allowed Charge.

If a Covered Person is referred to an Out-of-Network Provider by an In-Network Provider, the Plan will utilize the Provider's charge as the Allowed Charge.

If a Covered Person is not able to locate an In-Network Provider for Preventive Care Services, there will be no cost sharing for the Out-of-Network Provider's charges for those covered Preventive Care Services.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, upon request. This list will include Providers who specialize in obstetrics or gynecology.

Out of Country Care. This Plan will provide benefits for covered expenses Incurred outside the USA when there is an Emergency Condition. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. You may be required to pay the Provider at the time of service. If expenses outside the USA are Incurred, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where service are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan Administrator reserves the right to reimburse the Enrollee directly.

Coordination of Benefits. When services and supplies are rendered and billed by an In-Network or Out-of-Network Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and Medicare Secondary Payer rules. All benefits will still apply. Copayments still apply.

Deductibles/Copayments Payable by Plan Participants. Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one Deductible amount per Plan and generally it must be paid before any money is paid by the Plan for any Covered Charges. However, Covered Charges Incurred in, and applied toward the Deductible in the last three months of the Calendar Year will be applied to the Deductible in the next Calendar Year as well as the current Calendar Year. Each January 1st, a new Deductible amount is required. Deductibles accrue toward the 100% maximum Out-of-Pocket payment.

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments accrue toward the 100% maximum Out-of-Pocket payment.

COST MANAGEMENT SERVICES

Precertification or preauthorization does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to the POMCO Administrators Benefit Management Department at the time of the requested service authorization. All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions in force at the time services are rendered.

Cost Management Services Phone Number

Anthem Blue Cross/Blue Shield - 1.800.274.7767 (In-Network Providers only)
POMCO Administrators – 1.844.344.8320

Please refer to the Employee ID card for the Cost Management Services phone number.

This Cost Management program does not apply if your primary coverage is Medicare or another group health benefit plan.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least three days (business days) in advance of services being rendered or within three days (business days) after an emergency.

Any costs Incurred because of reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the 100% maximum Out-of-Pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(1) Precertification of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided (a detailed list of services requiring precertification is available upon request):

Home health care
Hospitalizations
Mental Disorder inpatient admissions
Physical Rehabilitation Facility stays
Skilled Nursing Facility stays
Substance Use Disorder inpatient admissions

Transplants, including but not limited to organ and stem cell transplants

(2) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(4) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least three days (business days) before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Member ID number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within three** days of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment.

Concurrent Review, Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called Case Management, shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Summary of Benefits

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to **Comprehensive Medical Benefits**, **Defined Terms**, and **Plan Exclusions**.

Plan Features	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Deductible per Calendar Year	$100 per individual $300 family maximum (when each of three Covered Persons has satisfied the $100 Deductible) In-Network and Out-of-Network Deductibles **are** combined.	
Carry-over Individual Deductible	Covered Charges incurred in, and applied toward the Deductible in the last three months of the Calendar Year will be applied to the Deductible in the next Calendar Year as well as the current Calendar Year.	
Common Accident Deductible	Family $100 Cumulative for two or more covered family members injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit. Expenses also count toward the Calendar Year Deductible.	
Network Copayment	$20 per Physician office visit Copayments do not apply to the Deductible	Does not apply
Percentage Coinsurance	The Plan pays 90% of the allowable Network fee for most covered services and supplies. See individual service type for details.	The Plan pays 80% of URC for most covered services and supplies. See individual service type for details.
Medical Out-of-Pocket (OOP) Limit Including Deductible and Copays, per Calendar Year • **East Side Teachers Association (Certificated)**	$1,000 per individual $2,000 per family	$1,000 individual $2,000 per family
• **Administrative, Adult Ed, Classified, Confidential Management**	$500 per individual	$1,000 individual
	In-Network and Out-of-Network OOPs **are not** combined. **Out-of-Pocket limit does not apply to:** Prescription Drug Out-of-Pocket amounts, specific benefits as noted in the Schedule of Benefits, any expenses for which benefits were initially paid at 100% of Allowed Charges, and any expenses more than Plan Maximums or over URC amounts. Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	
Out of Area Services	Services performed out of the California Anthem area will be covered the same as Out-of-Network. Except: Preventive care will be covered the same as In-Network.	
Ancillary Charges	Out-of-Network services for an Emergency Condition will be covered at the In-Network benefit level, using Provider charges as the Allowed Charge. If surgeon and facility are In-Network, Out-of-Network anesthesia charges will be allowed at the In-Network benefit level.	

Plan Features	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Cost Management Services Program/Precertification	Providers should call Anthem prior to Hospitalizations and before specific services are rendered. A detailed list of services requiring precertification is available upon request.	

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Abortion	See type of service rendered	See type of service rendered
	Only covered if determined to be Medically Necessary and life-threatening.	
Acupuncture	80% of Allowed Charges after Deductible (maximum $35)	80% of Allowed Charges after Deductible (maximum $35)
	Benefit is limited to $350 paid per Covered Person per Calendar Year combined In- and Out-of-Network.	
Allergy Injections	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Allergy Serum	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Allergy Testing	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Ambulance	90% of Allowed Charges after Deductible	90% of Allowed Charges after Deductible
	Professional and volunteer ambulance, train, and air ambulance are covered.	
Ambulatory Surgical Center, Freestanding	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Anesthesia	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.	
Biofeedback	Not covered	Not covered
Blood and Blood Product Services	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Cardiac Rehabilitation		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limit three times a week for 18 consecutive weeks.	
Chemotherapy		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Chiropractic Care	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Benefits are limited to total of 25 visits per Covered Person per Calendar Year combined In- and Out-of-Network. X-rays are covered under the Diagnostic Testing benefit. Maintenance Care is not covered.	
Clinical Trials (Excludes the Actual Clinical Trial)	See type of service rendered	Not covered
	Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.	
Consultation		
Inpatient Consultation	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient/Office	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
Second Surgical Opinion, Voluntary	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
Second Medical Opinion	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Dental Care, Limited	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
	Services available for accidental Injury to Sound Natural Teeth if performed within six months of Injury.	
Diabetic Education	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Diabetic Supplies/Equipment	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Syringes are covered under the Prescription Drug Benefits. Additional diabetic supplies are covered under your Prescription Drug Benefits.	
Diagnostic Testing		
Genetic Testing	Not covered	Not covered
Independent/Free-standing Laboratory	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Laboratory	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Machine Testing	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Professional Interpretation	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
X-ray	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Dialysis		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Durable Medical Equipment	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Oxygen	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Excludes services covered under the Preventive Care provision of the Plan.	
Food Products (Aminoacidopathies Formula, Enteral Formulas, Modified Solid Food Products)	Not covered	Not covered
Foot Care and Podiatry Services	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
	Routine foot care is not covered. **Exception:** Routine foot care is covered for patients with severe systemic disorders, such as diabetes. Medically Necessary Foot Orthotics are covered for arthritis, rheumatologic, neuropathic, diabetic or entrapment related foot problems.	
Hearing Aid/Exam	Not covered	Not covered
Home Health Care ☎	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to 100 visits (combined with Nursing, Private Duty limit) per Covered Person per Calendar Year combined In- and Out-of-Network. One HHC visit equals: - Up to four hours of home health aide care; or - Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.	
Hospice Care	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Bereavement counseling is not covered.	
Hospital Facility		
Inpatient Hospital ☎	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.	
Outpatient Hospital		
Clinic	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
Diagnostic Testing	See Diagnostic Testing	See Diagnostic Testing
Emergency Room for Emergency Condition and Related Charges	90% of Allowed Charges after Deductible	90% of Allowed Charges after Deductible

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Emergency Room for non-Emergency Condition and Related Charges	90% of Allowed Charges after Deductible	90% of Allowed Charges after Deductible
Outpatient Surgical Center	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Other Outpatient Hospital Services and Supplies	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Impotency Treatment	Not covered	Not covered
Infertility Services	Not covered	Not covered
In-Hospital/Facility Physician's Care	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Massage Therapy	Not covered	Not covered
Maternity Care		
Inpatient Hospital Facility ☎	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness.	
Prenatal, Delivery and Postpartum Care, Physician Charge	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Only In-Network midwives are covered. Related testing is covered separately per service type rendered (sonograms limit one per Pregnancy and amniocentesis only covered in connection with activity related to the survival of the fetus and for Covered Persons age 35 and older). Voluntary termination of Pregnancy is not covered.	
Medical/Surgical Supplies	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Mental Disorder Treatment		
Inpatient Facility ☎ General Hospital or Private Proprietary Psychiatric Facility Partial Hospitalization	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.	
Inpatient, Physician Charge	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Outpatient/Office Physician Charge	$20 Copay then 100% of Allowed Charges	$20 Copay then 100% of Allowed Charges
	Services must be rendered and billed by a licensed mental health professional performing services within the scope of their license. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered.	
Psychological Testing	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Newborn Care		
Circumcision	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.	
Nursing, Private Duty	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limit 100 visits (combined with Home Health Care limit) per Covered Person, per Calendar Year combined In- and Out-of-Network. Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.	
Obesity Treatment, Morbid	See type of service rendered	See type of service rendered
	Only allowed if due to another life-threatening condition (as determined by the Claims Administrator) surgical charges for Morbid Obesity will be covered if documented non-surgical obesity treatments have failed.	
Occupational Therapy		
Freestanding Facility	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Maintenance Care is not covered.	
Orthotics	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physical Rehabilitation Facility, Inpatient ☎	See Skilled Nursing Facility	See Skilled Nursing Facility

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Physical Therapy		
Freestanding Facility	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Maintenance Care is not covered.	
Physician Care		
Emergency Room		
Emergency Condition and Related Charges	90% of Allowed Charges after Deductible	90% of Allowed Charges after Deductible
Non-Emergency Condition and Related Charges	90% of Allowed Charges after Deductible	90% of Allowed Charges after Deductible
Home, Office, Clinic or Elsewhere	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. Outpatient Mental Disorder care, outpatient Substance Use Disorder care, outpatient consultations, surgical and obstetrical procedures, outpatient emergency room visits, rehabilitation therapy, Urgent Care Facility Physician charges and chiropractic care are not covered under this benefit.	
Urgent Care (Physician Charges)	See Urgent Care Facility	See Urgent Care Facility
Preadmission Testing	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Must be: - Performed on an outpatient basis within 3 days before a scheduled Hospital confinement; and - Your Physician ordered the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs with COB	See Prescription Drug Benefits	See Prescription Drug Benefits
Preventive Care (Includes all Ancillary Charges)	Please see www.HealthCare.gov/center/regulations/prevention.html for complete listing and frequencies, unless listed below.	
Contraceptive Management	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Medical benefits only: FDA-approved injectable contraceptives, implantable contraceptives, contraceptive patches, and contraceptive devices. Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion or removal of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.	
Nutritional Counseling (for adults with risk factors and for adults and children with obesity)	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Limited to 26 wellness visits (no more frequently than 1 visit every 2 weeks) per Covered Person per Calendar Year combined In- and Out-of-Network.	

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Mammogram	100% of Allowed Charges	80% of Allowed Charges after Deductible
	- at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer; - a single baseline mammogram for Covered Persons aged 35-39; and - age 40 or over for Covered Persons; cover once a year.	
Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Limit – One per year from age 50 (from age 40 for men at high risk) combined In- and Out-of-Network.	
Routine Adult Physical (over age 18)	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Includes routine exam and related screening tests based on current medical standards for preventive care. Immunizations follow the recommendations set by the Department of Health and Human Services Centers for Disease Control (CDC). Limited to one exam per Calendar Year, per Covered Person for any combination of In- and Out-of-Network Providers. This maximum does not apply to other screening services listed above/below.	
Routine Child Care (up to age 19)	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Coverage for health care visits and related testing follows the guidelines of the American Academy of Pediatrics (AAP). Coverage for immunizations follows the recommendations set by AAP or as set by the Department of Health and Human Services Centers for Disease Control (CDC). Routine newborn care is covered as shown above.	
Routine Vision Care	Not covered	Not covered
Tobacco Cessation Counseling	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Limited to two attempts per Calendar Year, combined In- and Out-of-Network. Each attempt includes a maximum of four intermediate or intensive sessions.	
Prosthetics	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Pulmonary Rehabilitation		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limit 36 visits per Lifetime, per Covered Person	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	Not covered	Not covered
Radiation Therapy		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Refractive Surgery	Not covered	Not covered

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Respiratory/Inhalation Therapy		
Freestanding Facility	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Skilled Nursing Facility (SNF), Inpatient ☎		
First 10 days	100% of Allowed Charges	100% of Allowed Charges
11-180 days	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Limited to 180 days per Lifetime per Covered Person combined In- and Out-of-Network. Room and Board charge limited to actual semi-private rate. Coverage for a private room will be limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.	
Outpatient Services	Benefits for outpatient SNF are the same as the benefits for outpatient Hospital diagnostic X-ray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown previously in this section.	
Speech Therapy		
Freestanding Facility	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient Hospital	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Physician Office	80% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Sterilization, Voluntary or Elective (Female)	100% of Allowed Charges	80% of Allowed Charges after Deductible
	Includes all related services such as anesthesia and facility charges.	
Sterilization, Voluntary or Elective (Male)	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Substance Use Disorder Treatment		
Detoxification	See type of service rendered	
Inpatient Facility ☎		
General Hospital or Certified Alcohol/Substance Use Disorder Facility Program Partial Hospitalization	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.	
Inpatient Physician Charge	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Outpatient/Office Physician Charge	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible

☎ = Benefits with this symbol require precertification. If you have any questions about the precertification process, claim status or medical plan benefits, call the POMCO Administrators Benefit Management Department at 1.844.344.8320.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Supplemental Accident Charge Benefit	Supplemental accident benefit of $500 (payable at 100% of Allowed Charges) if services are rendered within three months of Injury.	
Surgical Charge Benefit		
Assistant Surgeon	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Surgeon	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
	Excludes services covered under the Infertility provisions of the Plan.	
Therapeutic Injections	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
TMJ	Not covered	Not covered
Transgender Treatment	Not covered	Not covered
Transplants ☎	90% of Allowed Charges after Deductible	80% of Allowed Charges after Deductible
Urgent Care Facility	$20 Copay then 100% of Allowed Charges	80% of Allowed Charges after Deductible
	One combined Copay per date of service applies to all services billed by the facility/Physician. Includes all covered facility/Physician charges performed in the Urgent Care Facility.	
Vision Therapy	Not covered	Not covered
Wigs	Not covered	Not covered

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are generally separate from Medical Benefits and do not apply to the Deductibles, Copayments, and Out-of-Pocket limits for Medical Benefits.	
The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ProAct. Contact ProAct Customer Service Department toll-free at 1.877.635.9545 for details.	
Any one retail Pharmacy prescription or refill is limited to a 34-day supply. Any one mail order prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs have a quantity limit under the Plan. For additional information on medications, you may call ProAct Customer Service at 1.877.635.9545.	
Covered Drugs and Supplies	**Network and Out-of-Network**
Prescription Drug Benefit (ProAct)	**Note:** *You must pay applicable Copayments. The Plan pays the balance of Allowable Fees.* Copayments per prescription: (see copayment table below)
Prescription Drug Out-of-Pocket Limit	
East Side Teachers Association (Certificated)	$500 per person $1,000 per family
All Others	$4,500 per person $9,000 per family
	Out-of-Pocket limit does not apply to: Medical Out-of-Pocket amounts. Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.
	Benefit includes coverage for: Oral contraceptives Acne medication (prior authorization required) Tobacco cessation Erectile dysfunction medication (prior authorization required) Growth hormones (prior authorization required)

	In-Network		**Out-of-Network**
	Retail	**Mail Order**	**Retail only**
Generic	$10	$10	80%
Preferred and Non-Preferred Brand Name	$20	$20	80%

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

This document is intended to describe the benefits provided under the Plan, but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Claims Administrator if you have questions about specific supplies, treatments or procedures.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Generally, before benefits can be paid in a Calendar Year a Covered Person must meet the Deductible shown in the Schedule of Benefits. This amount will accrue toward the 100% maximum Out-of-Pocket payment.

Deductible Three Month Carryover. Covered Charges Incurred in, and applied toward the Deductible in the last three months of the Calendar Year will be applied toward the Deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate Deductibles for treatment of injuries Incurred in this accident; instead, only one Deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

PERCENTAGE COINSURANCE

Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges Incurred by a Covered Person.

COVERED CHARGES

Covered Charges are the Allowed Charges that are Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished.

BILL AUDIT

The Enrollee should check to verify the Hospital services are actually for the services and supplies actually received. The Enrollee should review the Explanation of Benefits received from the Claims Administrator with the Hospital-itemized bill for accuracy. If a discrepancy is found, the Enrollee should notify the Hospital. When the Hospital refunds the Claims Administrator, the Enrollee will receive 50% of the savings to the Plan.

MEDICAL SERVICES AND SUPPLIES

Abortion

Facility and other Provider charges for care and treatment related to Medically Necessary, life-threatening surgical abortions are covered.

Acupuncture

Acupuncture is covered when used for palliative pain relief and when performed by a certified acupuncturist. Acupuncture performed for any other reason is not covered.

Allergy Care

Benefits are available for allergy treatment including, but not limited to, office visits, serum, scratch testing and laboratory testing. Allergy serum covered under the Prescription Drug Benefit will not be covered as a Medical Services and Supplies Benefit.

Ambulance Charges

The Allowable Charges billed by a local land ambulance service for trips to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. In addition, land ambulance transportation from an inpatient (or other facility) to another facility (or other location) will be considered when found Medically Necessary and ordered by a Physician. Such transfers cannot be for the convenience of the patient or family members.

Charges for pre-Hospital medical Emergency Services are covered regardless of whether or not the Covered Person is actually transported to a Hospital.

Air or train ambulance may be reimbursed only when the patient's condition was so serious that the patient could not be transported safely by land ambulance. Air or train ambulance may also be reimbursed if the location from which the patient required emergency transportation was inaccessible by land ambulance. Transportation by air ambulance from one Hospital to another will be allowed if certified by the attending Physician as being Medically Necessary by reason of the severity of the Covered Person's condition.

Coverage is also available for transportation to the United States from a foreign country, including on a regularly scheduled flight on a commercial airline when:

(1) special and unique covered Hospital services are required which are not provided by a local Hospital;

(2) transportation is Medically Necessary as deemed by the Claims Administrator; and

(3) transportation is to the nearest Hospital equipped to furnish the services.

Professional and volunteer ambulance must charge for its services.

Ambulatory Surgical Center

As defined, for outpatient surgery. Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

Anesthesia

Benefits are available for administration of general anesthesia found Medically Necessary for covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the

assistant surgeon, or by a Hospital employee. Exception: Administration of anesthesia by a Dentist who performed the surgery is covered when the anesthesia is rendered during a covered oral surgical procedure. The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after surgery. Anesthesia administration expenses are not covered if the surgery is not covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.

Blood Services

Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing when found Medically Necessary. Administration of these items is included. Blood procurement charges or charges for maintenance of a blood bank are not covered.

Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled surgery that customarily requires blood transfusions.

Cardiac Rehabilitation

For outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free standing cardiac rehabilitation center. Services must be rendered by a Physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending doctor and found Medically Necessary due to certain medical conditions, such as post valvular or congenital heart surgery; post heart transplants; dilated cardiomyopathy; post myocardial infarction; post bypass surgery or angioplasty; or stable angina. The plan of care must be approved for benefits by the Claims Administrator. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to frequency up to three times per week and up to a maximum 18 consecutive weeks for an approved plan of care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits. Separate charges for use of exercise equipment are not covered.

Chemotherapy Benefits

This benefit applies when a chemotherapy charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A chemotherapy charge is the Allowed Charge of a Provider for chemotherapy.

The type of drug for which benefits are provided is limited to anticancer drugs that are not in an Investigational or Experimental stage to include antineoplastic agents (such as anticancer drugs) or agents used to destroy microorganisms (such as antibiotic drugs).

Oral chemotherapy, subcutaneous injections or intra-muscular injections are not covered under this chemotherapy benefit.

Chiropractic Care

Spinal manipulation/chiropractic services by a licensed doctor of chiropractic (DC) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening. See the Schedule of Benefits for limitations. Benefits are not available for vitamin supplements, lumbar supports, pillows or massage therapy.

Clinical Trials (In-Network Only)

The Plan will not cover the clinical trial. The Plan will only allow Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. **Exception:** Out-of-Network Providers will be allowed if an In-

Network Provider will not accept the patient.

Consultations, Specialist

A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations.

(1) **Inpatient Consultations.** Coverage is limited to one inpatient consultation per specialty for each inpatient stay.

(2) **Outpatient/Office Consultations.** Coverage for outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary.

(3) **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. If the consulting specialist renders the procedure, consultation benefits are not payable. If you or your Dependent seek a third opinion, benefits will be provided on the same basis as the second opinion. Whether or not the second (or third) opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient's decision whether to undergo the procedure.

Contact Lens/Eyeglasses

Initial contact lenses or glasses required following intraocular surgery or cataract surgery, or required to treat corneal disease. No other eyeglasses, contact lens or visual aids, or related exams are covered under this benefit.

Dental Care, Limited Coverage

Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Emergency repair due to Injury to Sound Natural Teeth within six months of the Injury.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within six months of the Injury.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diabetic Supplies, Equipment and Education

(1) The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered or recommended by a Physician and when they are found to be Medically Necessary according to the Plan provisions:

(a) Blood glucose monitors (standard) and blood glucose monitors for the visually impaired;

(b) Test strips for glucose monitors, visual reading and urine testing, lancets and automatic lancing devices;

(c) Injection aids;

(d) Cartridges for the legally blind;

(e) Data management systems;

(f) Insulin pumps or insulin infusion pumps when Medically Necessary and when conventional

injection therapy is found to be inadequate to treat the patient's condition.

Items such as alcohol, swabs, adhesive tape, and gauze are not covered. The following items are covered under only the separate Prescription Drug Expense Benefits: Insulin and oral agents to control blood glucose. Syringes are only allowed under the Prescription Drug Expense Benefit.

(2) Diabetic self-management education and education relating to diet may be covered for a covered Person with a diabetic condition. Self-management education or diet instruction will only be covered when the patient is initially diagnosed with diabetes or when a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self-management. These educational services will be covered when provided by:

(a) A Physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;

(b) A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a Physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient's area, the Plan may cover individual education;

(c) A professional Provider as described above may be covered for services rendered in the patient's home. However, it must be found to be Medically Necessary for the patient to receive services at home.

Diagnostic Testing, X-ray and Lab Charge Benefits

Diagnostic Testing, X-ray and Laboratory charges are the Allowed Charges for X-rays and laboratory tests. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

(1) Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.

(2) Diagnostic medical services (machine testing) such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician or covered facility.

(3) Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician or covered facility.

Coverage includes separate Physician's charges for interpretations of covered diagnostic services given by a Hospital, Skilled Nursing Facility or other covered facility.

Charges for the following will not be included in this section:

(1) premarital exams;

(2) routine physical exams;

(3) X-ray therapy or chemotherapy; or

(4) exams performed as part of dental work, eye tests or fitting of lenses for the eye.

Dialysis

The Enrollee's first 40 renal dialysis visits are allowed at the Allowed Charges minus any applicable Enrollee cost share (i.e., Deductible, Copayment and/or Coinsurance). For Out-of-Network Providers: Additional visits are allowed at a Reference Based Pricing amount as determined by the Claims Administrator or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge. Renal dialysis visits will not be subject to Out-of-Network limitations. For In-Network Providers: Additional visits will be allowed at the Allowed Charge, subject to any applicable Enrollee cost share (such as Deductible, Copayment and/or Coinsurance).

Benefits are available for service or supplies related to outpatient dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and home setting found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period).See the definition of Allowed Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Durable Medical Equipment

Rental of Durable Medical or surgical Equipment when ordered by the attending Physician and found Medically Necessary according to Plan provisions. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. Charges for delivery and service are not covered.

Oxygen and supplies for its administration when found Medically Necessary and appropriate for self-care home use.

Foot Care and Podiatry Services

Coverage includes services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet when appropriate. Charges for routine foot care are covered for patients with severe systemic disorders, such as diabetes. Medically Necessary foot orthotics are covered for arthritis, rheumatologic, neuropathic or entrapment related foot problems. Services or supplies for orthopedic shoes or shoe inserts are not covered (please refer to Plan Exclusions). Diabetic shoes are not covered.

Home Health Care Services and Supplies

Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

The Plan pays for covered charges for one Home Health Care Visit from any of the following: registered nurse; medical social worker; occupational, speech and physical therapists; and home health aide. A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services. This benefit does not provide for housekeeping services, hemodialysis or Maintenance Care.

Hospice Care Services and Supplies

Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(1) Bed patient either in a designated Hospice Unit or in a regular Hospital bed or in a Skilled Nursing

Facility;

(2) Day care service provided by the Hospice Agency;

(3) Home care and Outpatient Services provided by the Hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a home health aide;

(4) Physical, occupational, speech, and respiratory therapy;

(5) Medical social services and nutritional services;

(6) Laboratory, X-ray, chemotherapy, and radiation therapy when needed to control symptoms;

(7) Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature;

(8) Durable Medical Equipment; and

(9) Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency.

During this period of acceptance, all the patient's medical services must be provided by or obtained through the Hospice Agency. All services must be billed by the Hospice Agency. Bereavement counseling is not covered.

Hospital Charges

This benefit applies when a Hospital charge is Incurred for the care of a Covered Person's Injury or Sickness and during a Hospital confinement that starts while that person is covered for this benefit.

(1) **Inpatient Hospital Care.** The medical services and supplies furnished by a Hospital or a Birthing Center.

The Usual and Reasonable Charges for room and board are payable as described in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

The Plan pays the average semi-private rate for room and board charges by a Hospital or other covered inpatient health facility. If the inpatient facility does not have a semi-private rate, the rate shall be 80% of the room and board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for a private room will be covered if a private room is deemed to be Medically Necessary.

The allowed charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic X-rays and lab tests are payable.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable and Charge.

(2) **Clinic Services or Supplies.**

(3) **Outpatient Emergency Condition Care.**

(4) **Outpatient Surgical Care.**

(5) **Other Services and Supplies** such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.

Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid up to 50% above invoice or at the amount that the Claim Administrator determines to be the Usual and Reasonable Charge.

In-Hospital/Facility Physician's Care Benefits

This benefit applies when a medical charge is Incurred for the care of a Covered Person's Injury or Sickness during a covered Hospital/facility confinement.

However, a medical charge will not include:

(1) a charge for care not rendered in the presence of a Physician; or

(2) a charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required surgery.

IV Therapy/Infusion Services

Ambulatory or home intravenous services ordered by a Physician to include intravenous medications, blood, hydration and electrolyte replacement, and total parenteral nutrition.

Maternity

The Allowed Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your Spouse/Dependents. Coverage is not provided for expenses connected with elective abortion. The Plan excludes service or supplies related to surrogate maternity care. The payment for childbirth, cesarean section or other Medical Necessary termination of a Pregnancy will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

Ultrasound tests are limited to one during each normal Pregnancy. Amniocentesis is only allowed for patients age 35 and older; and in connection with activity related to the survival of the fetus.

Medical Supplies (Home Use)

Benefits are available for certain medical and surgical supplies used in the home when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not covered. Coverage is limited to the following items:

(a) Ostomy bags and supplies required for their use.

(b) Catheters and supplies required for their use.

(c) Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.

(d) Compression stockings, if determined to be Medically Necessary.

Mental Health Disorder Treatment

Covered Charges will include Medically Necessary care, supplies and treatment of Mental Disorders. The Plan shall comply with federal parity requirements. Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

(1) **Inpatient Treatment.** Medically Necessary services relating to the diagnosis and treatment of mental health disorders comparable to other similar Hospital benefits will be allowed. This includes Partial Hospitalization. Coverage includes residential treatment limited to facilities that meet the definition of Provider, Hospital or Psychiatric Facility and care is determined to be Medically Necessary. Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

(2) **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

- Psychological testing.
- Comprehensive psychiatric emergency programs performed on an outpatient basis.
- Services must be rendered and billed by a licensed mental health professional performing services within the scope of their license. Services billed by a Hospital or a mental health facility, Physician's corporation or clinic for the services of a similarly licensed Provider will also be covered. Services rendered by a CSW (clinical social worker), LCSW (licensed clinical social worker) or MFCC (marriage, family and child counselor) must be referred by a Physician.
- Intensive Outpatient Program treatment is covered under the Outpatient Treatment benefit.
- Family counseling will be allowed as long as the person is an immediate family member of a person diagnosed with a Mental Health Disorder and is covered under this Plan. Family therapy will be allowed regardless of the number of family members attending the family therapy session.

Newborn Care

The benefit is limited to the Allowed Charges made by a Hospital or Physician for routine pediatric care while the newborn Child is Hospital-confined as a result of the Child's birth. Charges for covered routine care will be applied toward the Plan of the covered child.

Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn Child is an eligible Dependent and is neither injured nor ill. If the newborn Child is injured or ill, please see the Hospital Charges section.

Nursing Care, Private Duty

The private duty nursing care by a licensed nurse (RN, LPN or LVN). Covered Charges for this service will be included to this extent:

(1) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and care must be so intense that the Hospital or Skilled Nursing Facility staff could not be expected to render such care. Shortage of general nursing staff does not establish Medical Necessity for private duty nurses.

(2) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown under Home Health Care Services and Supplies or billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services.

Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

A licensed practical nurse will be allowed if the doctor certifies that a registered nurse is unavailable for an approved plan of skilled nursing care.

Skilled nursing must be needed to manage the care of acutely ill patients and must not be ordered primarily at the request of a family or household member.

Obesity Treatment for Morbid Obesity

Only surgical benefits are available for treatment of Morbid Obesity if due to another life-threatening condition involving obesity, as determined by the Claims Administrator. There must be documentation provided that non-surgical treatment of obesity has failed. Morbid Obesity is defined by the Plan.

Occupational Therapy

Services rendered by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Orthotics/Braces

The initial purchase, fitting and repair of Orthotic appliances such as braces (not including dental braces), splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Medically Necessary foot Orthotics are covered.

Physical Rehabilitation Facility, Inpatient

See Skilled Nursing Facility benefit.

Physical Therapy

Services rendered by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable.

Physician Care

The professional services of a Physician for evaluation and management or therapeutic medical visits in an office, outpatient Hospital, clinic, home, or elsewhere. Services must be given and billed by covered healthcare Providers and found Medically Necessary according to Plan provisions. Consultations, surgical and obstetrical procedures, Mental Disorder care, Substance Use Disorder care, podiatrist care or foot care, rehabilitation therapies, are covered separately.

Preadmission Testing

The Medical Benefits percentage payable will be for diagnostic lab tests and X-ray exams when:

(1) performed on an outpatient basis within three days before a Hospital confinement; and

(2) related to the condition which causes the confinement.

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

Preventive Care Services

The Plan will comply with all mandated coverage provisions of the Patient Protection and Affordable Care Act. This list is subject to change based on evidence-based items or services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF); evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Heath Resources and Services Administration (HRSA) and/or the Bright Futures/American Academy of Pediatrics (AAP); and immunizations for

routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP). The Plan will comply within the first Plan Year after one year of the effective date of all new recommendations or guideline changes. The Plan will not cover any item or service that is no longer a recommended preventive service. Ancillary charges associated with any preventive care service will be available at no cost share for In-Network Providers. Preventive care services/routine well care is care by a Physician that is not for an Injury or Sickness. Please see www.HealthCare.gov/center/regulations/prevention.html for a complete listing and frequencies, unless listed in the Summary of Benefits.

Preventive care services/routine well care is care by a Physician that is not for an Injury or Sickness.

(1) **Contraceptive Management** – FDA-approved contraceptive methods prescribed by a professional Provider, sterilization procedures and patient education and counseling, not including abortifacient drugs.

- Medical benefits portion of the Plan covers: FDA-approved injectable contraceptives, implantable contraceptives, contraceptive patches, and contraceptive devices. Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion or removal of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.
- Prescription Drug benefits portion of the Plan covers: FDA-approved, Physician prescribed oral contraceptives, barrier methods (retail only), and emergency contraceptives (retail only).
- Benefits are not provided for any drug or device obtainable without a prescription. Male contraceptive medicines or devices are not covered, regardless of intended use; male elective sterilization is not covered under this benefit.

(2) **Mammogram.** Benefits are available for a routine mammogram:

- at any age for Covered Persons having prior history of breast cancer or whose mother or sister has a prior history of breast cancer;
- a single baseline mammogram for Covered Persons aged 35-39; and
- age 40 or over for Covered Persons; cover once a year.

(3) **Nutritional Counseling.** The Plan will cover nutritional counseling (for adults with risk factors and for adults and children with obesity) up to the benefit maximums shown in the "Schedule of Benefits". Services must be rendered by certified nutritionist or certified and registered dietician.

(4) **Prostate Exam.** Benefits are available for routine screening of the prostate gland, including digital rectal examination and PSA (prostate-specific antigen) testing.

- Coverage is limited to once per Calendar Year for men from age 50.
- Coverage is available for men at any age who have a prior medical history of prostate cancer and for men age 40 and older if determined to be at high risk for prostate cancer. Such high risk factors include a family history of prostate cancer and/or African-American ancestry

(5) **Routine Adult Physical**, to include screening tests and age-appropriate immunizations.

(6) **Routine Child Care** is routine care by a Physician that is not for an Injury or Sickness, to include health care visits and immunizations.

Coverage is intended to be consistent with the clinical standards set forth by the ACIP (Advisory Committee on Immunization Practices) of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians recommendations. If these standards change, the Plan will automatically cover the new recommended standards. Coverage is intended to be consistent with the clinical and frequency standards set forth by the American Academy of Pediatrics. If these standards change, the Plan will automatically cover the new recommended standards.

(7) **Tobacco Cessation Counseling** includes screening for tobacco use, and, for those who use tobacco products, up to two tobacco cessation attempts per year. For this purpose a cessation attempt includes coverage for (a) four tobacco cessation counseling sessions of 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior

authorization; and (b) all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care Provider without prior authorization.

Prosthetics

The initial purchase, fitting and repair of fitted Prosthetic devices which replace body parts. Replacement may be covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Pulmonary Rehabilitation

Is covered when found Medically Necessary and the services are performed by a Pulmonary Rehabilitation program approved by the Claims Administrator. Patients must meet the Medical Necessity criteria for Pulmonary Rehabilitation of the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) for patients with chronic pulmonary disease. The plan of care must be approved for benefits by the Claims Administrator prior to the start of treatment. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.

Radiation Therapy Benefits

This benefit applies when a chemotherapy or radiation charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A radiation charge is the Allowed Charge of a Provider for X-ray, radium or radiotherapy treatment.

Radiation charges will not include charges for diagnostic or cosmetic procedures.

Skilled Nursing Facility (SNF) Care

(1) **Inpatient SNF Services.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- **(a)** the patient is confined as a bed patient in the facility;
- **(b)** the confinement starts immediately after a Hospital confinement of at least three days;
- **(c)** the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities is limited to the maximum limit shown in the Schedule of Benefits.

(2) **Outpatient SNF Services**.

- **(a)** **Rehabilitative Therapy**. Benefits are available for outpatient physical therapy, cardiac rehabilitation, occupational, and speech therapy rendered to improve function lost due to an Illness or Injury. Such care must be ordered by the attending Physician and rendered by Professional Healthcare Providers licensed to render such care. Refer to the Schedule of Benefits for benefit limits.
- **(b)** **Other Outpatient Services and Supplies.** Benefits are available for other outpatient facility service or supplies when found Medically Necessary according to Plan provisions. Coverage includes all necessary supplies used during the covered treatment.

Speech Therapy

Services rendered by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.

Sterilization, Voluntary or Elective

Facility and other Provider charges for care and treatment related to voluntary surgical sterilizations are covered.

Substance Use Disorder Treatment

Covered Charges will include Medically Necessary care, supplies and treatment of Substance Use Disorders for services by a certified Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) inpatient or Outpatient Care. The Plan shall comply with federal parity requirements.

(1) **Inpatient Treatment.** Inpatient detoxification is considered a medical condition eligible for acute care Hospital benefits. Expenses for inpatient Substance Use Disorders (alcohol or drug abuse) rehabilitation are covered separately from detoxification. Medically Necessary services relating to the diagnosis and treatment of mental health disorders comparable to other similar Hospital benefits will be allowed. This includes Partial Hospitalization. Coverage includes residential treatment limited to facilities that meet the definition of Provider, Hospital or Substance Use Disorder Facility and care is determined to be Medically Necessary.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

(2) **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Substance Use Disorders for services at a certified alcohol or Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) relating to the diagnosis and treatment of alcoholism, substance use and dependency will be covered. Intensive Outpatient Program treatment is covered.

Family counseling will be allowed as long as the person is an immediate family member of a person diagnosed with a Substance Use Disorder and is covered under this Plan. Family therapy will be allowed regardless of the number of family members attending the family therapy session.

Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

Supplemental Accident Charge Benefit

This benefit applies when an accident charge is Incurred for care and treatment of a Covered Person's Injury and:

(1) the Injury is sustained while the person is covered for these benefits; and

(2) is for a Covered Charge Incurred within 90 days of the date of the accident; and

(3) to the extent that the charge is not payable under any other benefits under the Plan (other than medical benefits).

Benefits will be paid as described in the Schedule of Benefits.

Surgical Charge Benefits

(1) **Assistant Surgeon.** Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure. The maximum payment for all assistant surgeons for each surgical procedure is 20% of the value listed for surgery.

(2) **Surgeon.** This benefit applies when a surgical charge is Incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit.

Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowed Charge for the primary procedures; 50% of the Allowed Charge for each additional procedure performed in the same area of the body or through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowed Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowed Charge for that procedure.

(3) **Reconstructive Surgery.** Reconstructive mammoplasties will be considered Covered Charges. The federally mandated mammoplasty coverage will include reimbursement for:

(a) reconstruction of the breast on which a mastectomy has been performed,

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(c) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(4) **Cosmetic Surgery** and related charges are only covered if:

(a) within 12 months after and as a result of an Injury sustained while covered under this Plan;

(b) for replacement of diseased tissue surgically removed while covered under this Plan; and

(c) repair of bodily damage covered by disease and/or radiation treatment while covered under this Plan.

Transplants - Organ/Autologous Bone Marrow/Stem Cell Transplants

Benefits are available for expenses related to non-Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Investigational unless specifically included by the medical community in California. Transplants must meet the criteria set forth by the medical community in California for coverage to be considered for coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by the medical community in California or that fail to meet the medical community in California’s criteria for coverage. Plan coverage for Hospitals will be based on the same criteria set forth by the medical community in California’s criteria. If the medical community in California restricts coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital.

Benefits will be available for the following in connection with a covered transplant.

(1) **Recipient Expenses**. Coverage includes all Plan benefits available for Medically Necessary care and treatment related to covered organ transplants including, but not limited to; pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient’s transplant surgery and recovery; and post discharge care.

(2) **Donor Expenses**.

(a) Coverage includes expenses Incurred by the live donor(s) for expenses related to

procurement of an organ and for transportation of the organ(s) *to the extent such charges are not reimbursed by the donor's plan.*

(b) If you or your Dependent act as a donor, the donor expenses ***will not*** be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.

Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the services were rendered before such date. No benefits will be paid for pre-transplant testing in connection with a search for a donor who is not a family member.

(3) **Autologous Bone Marrow/Stem Cell.** Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants, except for the following (and only then for candidates who meet established national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under the medical community in California's guidelines. If the medical community in California's guidelines change, adding or deleting coverage under the medical community in California, this Plan will include or exclude those procedures. Recipient and donor expenses for covered procedures will be considered on the same basis as organ transplants shown above.

Urgent Care Facility

As defined. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on an active basis.

Advanced Physician Care Extender or Physician Extender includes Physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

Allowed Charge (or Allowable Fee) - The Usual and Reasonable Charges as determined by the Claims Administrator for Covered medical services rendered and billed by a covered out-of-network Provider. If billed by a Network Provider, the term Allowed Charge means the Network scheduled allowance or negotiated allowance based on the Provider's Network agreement with the Claims Administrator. If Medicare is primary, the Allowed Charge could be based on Medicare's allowance or limiting charges. **Exception:** When Medicare is the secondary payer under the Medicare Secondary Payer rules for ESRD (based on the Covered Persons eligibility, not their enrollment in Medicare), the Allowed Charges for covered Out-of-Network outpatient renal dialysis services are payable up to a Reference Based Pricing Amount or at the amount that the Claims Administrator determines to be the Usual and Reasonable Charge.

The Plan will not pay charges that exceed Allowed Charge. The Enrollee is responsible for payment of any charges that are not allowed under the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (RNs) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Care, or a national accreditation organization recognized by the Claims Administrator, or approved by Medicare to render outpatient surgery services. If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Facility.

Approved Clinical Trial - a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:

- Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;
- Study or trial conducted under FDA approved investigational new drug application;
- Drug trial exempt from FDA approved investigational new drug application;
- Or as amended by the federal Patient Protection and Affordable Care Act.

Biomechanical Prosthetic Device is a Prosthetic device that utilizes a computer microchip, myoelectric technology or other similar technology to control movement or use.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (RN) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

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

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is any person eligible and enrolled for benefits or coverage under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

Disposable supplies may be allowed if required to operate the medical equipment.

Emergency Medical Condition - a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy to the health of an individual (including the health of a pregnant woman or her unborn child) or others, if severe behavioral condition; impairment to bodily function; dysfunction of any organ; or serious disfigurement.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services to evaluate an Emergency Condition and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is a, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. Former Employees or Retirees may also be designated Employees if so designated by the Employer eligibility requirements. See also Active Employee; Retired Employee.

Employer is East Side Union High School District.

Enrollee is an eligible Employee, Retiree, or COBRA participant under whose Member ID number enrollment is made.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the US Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

If any of the entities used to determine the Investigational status of a drug, device, supply, treatment or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactive, the Plan will make payment for related retroactive Incurred expenses upon appeal.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement (or convalescent nursing home/extended care facility/Skilled Nursing Facility); and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical social services; medical supplies; and laboratory services by or on behalf of the Home Health Care Agency.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, or a national accreditation organization recognized by the Claims Administrator; or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

Hospitalist is a Physician that assumes the care of a Hospitalized patient and acts as a primary doctor while a patient is in a Hospital.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Immediate Relative of patient or Enrollee/Domestic Partner - Any of the following:

(1) Spouse of the patient or Enrollee;

(2) Natural or adoptive parent, Child or sibling;

(3) Stepparent, stepchild, stepbrother or stepsister;

(4) Father-in-law, mother-in-law, brother-in-law, or sister-in-law;

(5) Grandparent or grandchild; or

(6) Spouse of grandparent or grandchild.

Incurred means those services or supplies given to or received by a Covered Person. Such expenses shall be considered to have accrued at the time or date the service or supply is actually provided.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Program (IOP) is a licensed free-standing or Hospital-based program that includes half-day (i.e., fewer than four hours/day) partial hospitalization programs. IOPs provide services for at least three hours per day for two or more days per week and can be used to treat Mental Health Disorders or can specialize in the treatment of co-occurring Mental Health Disorders and Substance Use Disorders.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations for Covered Charges. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maintenance Care - Care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; is not Experimental or Investigational or not of an educational nature; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claims Administrator reserves the right to decide, in its discretion, if a service or supply is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Health Disorder in the current edition of International Classification of Diseases, published by the US Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. Alternatively, a BMI (body mass index) value greater than 39 may be used to diagnose Morbid Obesity.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

Orthotics - An external appliance or device intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

Out-of-Pocket means the patient liability portion of the percentage co-payment, Deductible and Copayments.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization (PHP) program or day/night program is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts at least 20 hours per week and no charge is made for room and board. Partial Hospitalization also encompasses partial hospitalization programs that provide overnight boarding.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Certified Nurse Anesthetist, certified psychiatric nurse, licensed professional counselor, Licensed Professional Physical Therapist, certified registered or Licensed Clinical Social Worker (for care of Mental Disorders), Master of Social Work (MSW), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (PhD), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the East Side Self-Funded PPO Plan, which is a benefits plan for certain Active Employees and Retired Employees of East Side Union High School and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetics - The making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

Provider - Any legally licensed Physician or any physical therapist, speech therapist, certified or Licensed Clinical Social Worker (for Mental Disorder care), or other health care Providers giving a covered service ordered by a Physician. Any licensed independent laboratory, Hospital, Skilled Nursing Facility, Substance Use Disorder Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for Covered Services given by covered Physicians or other healthcare Providers that would otherwise be covered by the Plan. Also, see definitions for certain Providers. To be covered, a Provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Psychiatric Facility: A private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator as an inpatient facility for the treatment of Mental Disorder and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorder.

Pulmonary Rehabilitation is an individualized therapeutic multidisciplinary program of care for patients with chronic respiratory disease who remain symptomatic or continue to have decreased function despite standard medical treatment. Pulmonary Rehabilitations' goals are to reduce symptoms, optimize functional status, increase participation, and to train patients to successfully manage their disease process, and improve the overall quality of life for patients with chronic respiratory disease.

Qualified Individual is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Rehabilitation Facility means a facility established, equipped and operated, according to the applicable laws of the jurisdiction in which it is located to provide restorative therapy to disabled persons on an inpatient or outpatient basis. The facility must be approved by the Commission on Accreditation of Rehabilitation Facilities

(CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or a national accreditation organization recognized by the Claims Administrator, or be a Medicare approved facility for Medicare Part A Skilled Nursing Facility benefits. See also Skilled Nursing Facility.

Retired Employee or Retiree is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Routine Patient Costs include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

(8) It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Claims Administrator.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth are natural teeth that are fully restored to function; or do not have any decay; or that are not more susceptible to Injury than virgin teeth; or do not have significant periodontal disease.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Use Disorder Facility - An agency or freestanding facility or a Hospital center that is certified by the California State Department of Health Care Services (DHCS) for the treatment of Substance Use Disorders (drugs and alcohol). For services given outside /California, the facility must be certified by a state agency similar to the California State DHCS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for the treatment of Substance Use Disorders.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Total Disability (Totally Disabled) means:

In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. The Employer will determine Total Disability.

In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Tricare is the Department of Defense's health care program for members of the uniformed services, their families and survivors.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by Physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a Physician's office.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

To calculate reimbursements, the Plan will use the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period means the time between the first day of employment and the first day of coverage under the Plan.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered. Medical or surgical termination of intact, intrauterine Pregnancy prior to viability. Hysterectomy to terminate Pregnancy.

(2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(3) **Anesthesia.** Services or supplies for the administration of anesthesia for any surgery or treatment that is not covered by the Plan.

(4) **Automobile Insurance, No-Fault Auto Insurance** for which the Covered Person is eligible to receive benefits through mandatory No-Fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is made for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the No-Fault coverage due to its deductible or maximum payment limits will NOT be covered under this Plan to the extent Allowable Fees would have otherwise been payable by this Plan. **Note:** No-Fault and motor vehicle liability coverage is considered another plan under the Coordination of Benefits provision of this Plan.

(5) **Biofeedback.**

(6) **Complications of Non-Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(7) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of a, or as a result of, cosmetic surgery (including re-implantation). Services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. Exception: Charges in connection with cosmetic surgery are covered only if:

- **(a)** within 12 months after and as the result of an Injury sustained while covered under this Plan;
- **(b)** for replacement of diseased tissue surgically removed while covered under this Plan;
- **(c)** repair of bodily damage covered by disease and/or radiation treatment while covered under this Plan;
- **(d)** functional congenital anomalies; or
- **(e)** non-functional congenital anomalies while the participant is less than 12 years of age or after said age if Medical Necessity for delaying the procedure is clearly established.

(8) **Counseling/Analysis/Support Groups**. Services or supplies primarily directed at raising the level of consciousness, social enhancement, counseling limited to everyday problems of living such as marriage counseling, family counseling, pastoral counseling; gender identity counseling, sex therapy, or support groups.

(9) **Custodial Care.** Services or supplies provided mainly as a rest cure, Maintenance or Custodial Care or domiciliary care consisting chiefly of room and board and billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, or any similar facility or institution.

(10) **Dental Care.** Services or supplies related to care or treatment of the mouth, teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia (including braces), implants or other services. Adjustments, services or supplies related to appliances for treatment of Temporomandibular Joint disorders (TMJ) or similar disorders. Hospital care when dental services (as distinguished from oral surgery) are rendered.

Exceptions: Limited dental care (including Hospital care) given for Accidental Injury to Sound Natural Teeth within six months following the accident; in no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices.

(11) **Durable Medical Equipment/Braces/Prosthetics/Devices.** Services or supplies related to duplicate medical equipment, braces, Prosthetics or other devices or the replacement of Durable Medical Equipment, braces, Prosthetics or other devices due to loss, theft or destruction, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The purchase of Durable Medical Equipment that can be rented unless the length of time that the equipment will be needed makes the purchase less costly than the rental. The purchase or replacement of any Biomechanical Prosthetic Device. Deluxe or specialized equipment when standard equipment is adequate for the patient's condition. Services or supplies related to durable equipment, braces, Orthotics, or splints that are primarily for athletic use.

(12) **Educational/Cognitive/Therapy for Developmental/Birth Defects.** Services or supplies related to special education or cognitive therapy for any reason, or for occupational, physical, psychological or other therapy that is primarily directed at educational or mental or physical development for learning deficiencies, mental retardation, developmental disorders, birth defects, autism, spinal bifida, educational or occupational deficits or perceptual and conceptual dysfunctions. This applies whether or not associated with manifest mental Illness or other disturbances. Services or supplies considered remedial or educational. Services and supplies that any school system is required to provide under any law. This applies even if the Covered Person, parent or guardian does not seek provision of such services or supplies through the school system. Treatment of hyperkinetic syndromes are excluded.

(13) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(14) **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician- supervised cardiac rehabilitation, approved Pulmonary Rehabilitation programs, occupational or physical therapy covered by this Plan. Physical fitness equipment, hot tubs, heated spas, pools, or memberships to health clubs are not covered.

(15) **Experimental, Not Medically Necessary, or Obsolete Care.** Care and treatment that is either Experimental/Investigational, not Medically Necessary, or care that is considered obsolete, unless as required by federal law. Inpatient care that is not consistent with the diagnosis and treatment of the condition requiring Hospitalization is not covered.

(16) **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Services and supplies related to vision therapy. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(17) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). Orthopedic shoes (except when joined to braces) or other supportive foot devices.

(18) **Foreign Travel.** Care, treatment or supplies out of the USA if travel is for the sole purpose of obtaining medical services or care/treatment that is non-emergent.

(19) **Gender Changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or gender reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(20) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(21) **Government Facilities/Institutions.** Services or supplies received in an institution owned or operated by federal, state or local governments. However, benefits will be available for covered expenses for the following exceptions:

(a) Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces.

(b) State or local government owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services.

(c) State or local government owned mental health facility.

(d) Government owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or Substance Use Disorder treatment facility.

(e) USA military acute care Hospital or Skilled Nursing Facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel.

(f) Any government facility, if the patient with a sudden and serious Illness or Injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.

(22) **Growth Hormone Therapy** for the treatment of Turner's syndrome, and other conditions characterized by short stature, unless there is unequivocal evidence of pituitary gland failure as determined by the Claims Administrator.

(23) **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(24) **Hearing.** Services or supplies related to hearing aids, tinnitus masking devices (or similar devices), communication devices, and examinations to determine the need for, adjustments or repair of them. Exceptions: The initial hearing aid for hearing loss caused by a covered surgical procedure rendered to a patient while he is covered under the Plan; services covered under the well adult or well child sections of this Plan and FDA approved cochlear implant will be covered under the Plan's Prosthetic benefit.

(25) **Home Births.** Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

(26) **Hospital/Facility Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital, Skilled Nursing Facility, or any inpatient facility where care is received and paid by the Hospital or facility for the service. **Exception:** Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.

(27) **Hypnosis and Continuous Epidural Anesthesia** when used for control of chronic pain (except that associated with terminal cancer) or for control of acute post-operative pain (except when used following certain select procedures, as determined by the Claims Administrator).

(28) **Illegal Acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any crime punishable by any term of imprisonment. Also excluded, any finding of DWI, DUI or similar impaired-driving funding. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(29) **Illegal Care.** Services or supplies considered illegal according to the laws of the state of jurisdiction or according to federal law. Benefits will not be provided if these excluded services are obtained outside the USA even if these services are legal in the foreign country.

(30) **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(31) **Immediate Relative or Self Giving Professional Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home, or self, or is related to the Covered Person as a Spouse/Domestic Partner, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

(32) **Implants.** Claims for implants billed by a facility may be denied unless they are submitted with the invoice.

(33) **Impotence.** Care, treatment, services, or medications in connection for treatment of impotence.

(34) **Infertility**. Care, supplies, services and treatment for Infertility, artificial insemination, or in vitro fertilization, including implantation of fertilized egg embryo or gamete transfer procedures and related care. Personal and other drugs used for the induction of ovulation; ultrasound monitoring for the evaluation or treatment of Infertility.

(35) **Inpatient Room and Board Charges** in connection with a Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Exception: Care rendered in a Skilled Nursing Facility or Rehabilitation Facility as indicated elsewhere in this document as covered.

(36) **Inpatient Room and Board Charges** in connection with a Hospital stay primarily for diagnostic tests or therapy which could have been performed safely on an outpatient basis. Inpatient Hospital stays exclusively required for the purpose of administering general anesthesia.

(37) **Insertion of Laminaria,** except to initiate labor care of intrauterine death of fetus

(38) **Military Service.** Services or supplies for which benefits are, or can be, provided due to related Illness or Injury arising from the past or present military service in the armed forces of any government or international authority.

(39) **Missed Appointments/Phone Consultations/Forms/No Care Given.** Medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby services. Services or supplies not actually received by the patient or Incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors.

(40) **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force. Exception: Services received at a non-governmental charitable research Hospital that meets the following criteria:

- **(a)** must be internationally known as being devoted mainly to medical research;
- **(b)** at least 10% of its yearly annual expenditure must be spent on research not directly related to patient care;
- **(c)** at least 1/3 of its gross income must come from donations or grants other than gifts or payments for patient care;
- **(d)** it must accept patients who are unable to pay; and
- **(e)** 2/3 of its patients must have conditions directly related to the Hospital's research.

(41) **No Obligation to Pay.** Charges Incurred for which the Plan has no legal obligation to pay.

(42) **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(43) **Non-Compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(44) **Non-Traditional** medical services, treatments and supplies (e.g., alternative medicine) which are not specified as covered under this Plan.

(45) **Not Specified as Covered.** Medical services, treatments and supplies which are not specified as covered under this Plan.

(46) **Nutritional Counseling** of food supplements, except as mandated by federal law.

(47) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as required by federal law. Exception: Surgical treatment of obesity to treat another life-threatening condition involving obesity will be allowed.

(48) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Dependents do not claim the entitled benefits.

(49) **Other Plan/Benefit Penalties/Primary Care Network/HMO Network**. Services or supplies to the extent such expenses were disallowed by a primary health Plan due to failure by their Enrollee or participant to follow the requirements of its benefit management or managed care program, preadmission reviews, second surgical opinion, or any other reason, including failure to abide by the primary care Physician network established by a health maintenance organization that is a primary plan payer.

(50) **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, support stockings, non-Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds, as well as telephone, radio, television, or barber services charged by any facility or other Provider.

(51) **Plan Design Excludes.** Charges excluded by the Plan design as specified in this document.

(52) **Police Custody/Court Ordered Services**. Services or supplies Incurred while the Covered Person is in police custody, jail or in prison, or services or supplies related to court ordered evaluations for Mental Disorders or substance (drug and alcohol) abuse.

(53) **Prohibited Referral**. Any Pharmacy services, clinical laboratory, radiation therapy, X-ray or imaging services which were provided pursuant to a referral prohibited by the California State Health and Safety Code or similar laws in other states, if service is rendered out of California.

(54) **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(55) **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(56) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(57) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan, except as specifically stated under Extension of Coverage.

(58) **Subrogation/Third Party Claim.** Services or supplies for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or actions) other than from an insurance carrier under an individual policy issued to you or your Dependent. Exception: Conditional payments shown in the section entitled Third Party Recovery Provision.

(59) **Surgery for Psychological or Emotional Reasons.**

(60) **Surgical Assistance**. Expenses billed for surgical assistance in a Hospital if the Hospital has qualified staff Physicians to provide such assistance. Expenses billed for surgical assistance by Providers other than qualified surgeons (MD, DO, or a DPM for foot surgery, or a DDS, DMD for covered oral surgery).

(61) **Surgical Sterilization Reversal.** Care and treatment for surgical sterilization reversal.

(62) **Surrogate Pregnancy.** Services or supplies related to surrogate maternity care, including but not limited to, those needed to initiate a Pregnancy, prenatal care, delivery or other procedures, and postnatal care or any other related care of the Pregnancy. Benefits are available for newborns who meet the Child eligibility requirements and who are enrolled under family coverage.

(63) **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or transportation services specifically listed in this Plan.

(64) **War.** Any loss that is due to a declared or undeclared act of war. Conditions caused by the release of nuclear energy, whether or not the result of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. ProAct is the administrator (PBM) of the Pharmacy drug plan.

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Contact the PBM Customer Service Department toll-free at 1.877.635.9545 for details.

Copayments

The copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Summary of Benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one Pharmacy prescription is limited to a 34-day supply. Any one mail order prescription is limited to a 90-day supply.

Copayment is waived for Generic Prescription Drugs that are mandated as covered under the “Preventive Care” provisions of the federal Patient Protection and Affordable Care Act. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by the PBM. Contact the PBM Customer Service Department for details on quantity limits and “Preventive Care” provisions under the Plan.

Prescription drugs will be covered if a drug is purchased from a non-participating Pharmacy or a participating Pharmacy when the Covered Person's ID card is not used.

Percentages Payable

The percentage payable amount is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Summary of Benefits. This amount is not a Covered Charge under this Plan or the medical plan.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the PBM is able to offer Covered Persons significant savings on their prescriptions.

Out-of-Pocket Limit

Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Summary of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

Pre-authorization Requirements

Some drugs require pre-authorization before benefits become available. The participating Pharmacy or mail order Pharmacy will not provide coverage unless drugs have been approved for benefit payment. If a Pharmacy advises you that you need pre-authorization, you should call the PBM Customer Service Department for assistance. Failure to obtain prior authorization will result in denial of benefits.

Specialty Pharmacy Services

The PBM has a special program for specialty drugs developed for chronic and or complex Illnesses including but not limited to crohn’s disease, hepatitis C, osteoarthritis, rheumatoid arthritis, Infertility, and pulmonary disease. These drugs may have special handling storage, shipping requirements, or require disease specific treatment programs. They may be injections, infusions, or oral products.

All drugs deemed specialty drugs by the PBM and received by the PBM mail order will be sent to the Noble Health Services Specialty Pharmacy to be filled. A complete list of drugs available under the specialty Pharmacy is available by calling the Specialty Pharmacy's Customer Service Department's toll-free number: 1.888.843.2040. Note: Specialty drugs will be covered at the retail pharmacy for the first 90 day supply.

Vacation Supply

A supply of medication may be replenished before a normal refill date when needed for a vacation trip. To obtain authorization for an advance supply of drugs, you must phone the PBM for the Pharmacy Benefit Program toll-free. This means that you may receive up to a 90-day supply, limit one fill per Calendar Year. You must pay the applicable multiple Copayment for a vacation supply.

Generic Drug Substitution Program

As part of a continuing effort to control costs and preserve the quality of the Plan, you are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is chemically equivalent to the original Brand Name Drug. The only difference is that the Brand Name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the Generic manufacturer does not incur research costs and can charge significantly less for the drug. Since Generic Drugs cost less than Brand Name Drugs, cost savings result for you (a lower percentage payable liability amount) and the Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes contraceptives (including oral contraceptive, injectable contraceptives and contraceptive devices), but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

(5) Weight loss medication for Morbid Obesity (with preauthorization).

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

(3) Quantity limits that could apply to controlled substances based on state regulations.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite Suppressants/Dietary/Vitamin Supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride or other drugs as required by federal law or indicated as covered in the Plan.

(3) **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription, excluding contraceptive devices. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs Obtained Outside the USA.**

(6) **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A (except with the diagnosis of acne) or medications for hair growth or removal.

(7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person, except as required by federal law.

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(10) **Immunization.** Immunization agents or biological sera. Covered vaccinations administered at the pharmacy will be allowed.

(11) **Infertility.** A charge for Infertility medication.

(12) **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(13) **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(15) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(17) **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or drugs as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act.

(18) **Off Label Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Allowed Charges/benefits are generally paid directly to you unless you direct payment to the Provider with written authorization. This Plan does not recognize assignments to Providers, Physicians or Hospital for any reason including fiduciary matters. Direct payments to a Provider, Physician or Hospital does not constitute a waiver of this anti-assignment provision.

When the claim is processed, POMCO Administrators will prepare an Explanation of Benefits Statement. This information should be carefully reviewed to make sure the charges were submitted to POMCO Administrators correctly and that the claim was processed accurately.

Generally Providers directly bill for their charges. However, if they do not and the Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from www.MyPOMCO.com or contact the Human Resources Department for assistance.

(2) Complete and submit the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the Provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Member ID number
- Name of patient
- Name, address, telephone number of the Provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

POMCO Administrators
2425 James Street
Syracuse, New York 13206

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within a reasonable timeframe from the date services were Incurred. **Claims filed later than one year from the date services were Incurred will be declined** (except in the case of legal incapacity of the Covered Person). Benefits are based on the Plan's provisions at the time the charges were Incurred.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS REVIEW PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. A claim does not include a request for a determination of an individual's eligibility to participate in the Plan. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination".

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal". If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination". If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost

Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal
Review of adverse benefit determination	60 days

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination or Final Adverse Determination. The notice will state, in a manner calculated

to be understood by the claimant:

(1) The date of service, the health care Provider, and the claim amount, if applicable.

(2) The specific reason or reasons for the adverse determination.

(3) Reference to the specific Plan provisions on which the determination was based and the Plan's standard, if any, that was used in denying the claim.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal appeals and external review procedures, including information about how to initiate an appeal, and the time limits applicable to such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) The claimant will also automatically be provided free of charge with any new or additional rationale or evidence considered, relied upon, or generated by the Plan, or at the direction of the Plan, in connection with the Claim with sufficient notice, assuming the Plan has received the information in a timely manner, so that the claimant has a reasonable opportunity to respond.

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

(9) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided upon request.

INTERNAL APPEALS

First Appeal Level. This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended. When a claimant receives an Adverse Benefit Determination, the claimant or an authorized representative acting on behalf of the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. Submit all appeals to:

(1) **Medical Benefits:** Anthem Provider: Anthem Blue Cross, PO Box 60007, Los Angeles, CA 90060-0007; non-Anthem Provider and Enrollee: POMCO Administrators, Appeals Department, PO Box 6329, Syracuse, NY 13217.

(2) **Prescription Drug Benefits:** ProAct, 1226 US Highway 11, Gouverneur, NY 13642.

The period of time within which an Adverse Benefit Determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

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

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by someone who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based 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 Plan or Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

Important: External appeals must be filed within four months from the date upon which you receive written notification from the Plan that the First Appeal Level has upheld the denial regardless of whether you choose to file a Second Appeal Level appeal as shown below. By deciding to file a Second Appeal Level appeal you are not waiving your option to file an External Appeal, however, in doing so you may miss the four month External Appeal filing deadline.

Second Appeal Level. When a claimant receives an Adverse Benefit Determination regarding the First Appeal, the claimant or an authorized representative acting on behalf of the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. Submit all appeals to:

(1) **Medical Benefits:** Anthem Provider: Anthem Blue Cross, PO Box 60007, Los Angeles, CA 90060-0007; non-Anthem Provider and Enrollee: POMCO Administrators, Appeals Department, PO Box 6329, Syracuse, NY 13217.

(2) **Prescription Drug Benefits:** ProAct, 1226 US Highway 11, Gouverneur, NY 13642.

EXTERNAL APPEALS

(1) Your Right to an External Appeal

This provision shall be in accordance with the federal Patient Protection and Affordable Care Act and its regulations, as amended.

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit), or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the state to conduct such appeals.

(2) Your Right to appeal a Determination that a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's Medically Necessary requirements, you may appeal to an external appeal agent if you satisfy the following two criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Plan; and

- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

(3) Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the Plan has denied coverage on the basis that the service is an Experimental or Investigational treatment, you must satisfy the following two criteria:

- The service must otherwise be a Covered Service under the Plan; and

- You must have received a Final Adverse Determination through the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

  Your attending Physician must also certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

  In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 US residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

(4) The External Appeal Process

If, through the Plan's internal appeal process, you have received a Final Adverse Determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an Experimental or Investigational treatment you have four months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external

appeal. If the Plan fails to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the Final Adverse Determination issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You must then submit the completed application to the Claims Administrator at the address indicated on the application. If you satisfy the criteria for an external appeal, the Claims Administrator will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your Physician, or the Plan. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health, or ability to regain maximum function; or if you received Emergency Services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment the Plan will provide coverage subject to the other terms and conditions of the Plan. Please note that if the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-Experimental or non-Investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

The Plan will charge you a fee of $25 for an external appeal, not to exceed $75 in a single Plan Year. The external appeal application will instruct you on the manner in which you must submit the fee. If the external appeal agent overturns the denial of coverage, the fee shall be refunded to you.

(5) Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the Claims Administrator. You may appoint a representative to assist you with your external appeal request; however, the Claims Administrator may contact you and request that you confirm in writing that you have appointed such representative.

Your completed request for appeal must be filed with the Plan within four months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to

grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover Experimental or Investigational treatments. However, the Plan shall cover an Experimental or Investigational treatment approved by an external appeal agent in accordance with the External Appeal Section of the Plan. If the external appeal agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Plan for non-Experimental or non-Investigational treatments provided in such clinical trial.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse/Domestic Partner is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. Exception: See also Medicare Integration described below.

Benefit Plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans or programs required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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

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

For Medicare integration, see section below.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall NOT pay excess benefits or reimbursement for vehicle plan deductibles. This Plan shall NOT be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow the National Association of Insurance Commissioners (NAIC) model regulations for coordination of benefits. Current regulations are shown below. If these regulations change, the Plan will automatically follow the amended regulations.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member, subscriber, policyholder, or retiree) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of either a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items **(i)** and **(ii)** above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situation in which a person who is covered a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can

provide details on enrollment requirements and any penalties for late enrollment.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a state child health plan to the extent required by federal law.

(6) If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

MEDICARE

If Medicare is primary for you or your Dependent, the benefits of the Plan will be integrated as follows:

(1) **Medicare Payment Integration**. The Plan determines the allowable fee first, and then pays the difference between the allowable fee and Medicare's payment up to the lesser of the balance of the bill or the Plan's normal benefit.

(2) **Not Enrolled in Medicare**. This integration will apply to persons eligible for Medicare whether or not they are actually enrolled in Medicare or incur services in a Veterans Administration Hospital/federal facility.

If Medicare is primary for an eligible person who is not enrolled in Medicare Part A and Part B or in Part C, the Medicare benefit will be estimated and used to reduce Allowable Fees. This could result in significant reduction or denial of the Plan benefits. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

For services Incurred in a Veterans Administration Hospital/federal facility which are not billable to Medicare, benefit integration will be estimated. Part A services will be estimated according to Medicare payment rules. Part B will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits.

(3) **Medicare Private Contract Options**. This integration will apply to persons eligible for Medicare primary benefits if Medicare benefits are not paid due to a Medicare Private Contract Option with Physicians and certain other practitioners. (When a Medicare beneficiary agrees to the terms of a Private Contract with certain Providers, Medicare will not pay. The patient is responsible for the entire charge. The Provider may bill more than the charges allowed by Medicare.) Under this Plan, if a private contract is used, Medicare benefits will be estimated. Part A services will be estimated according to Medicare payment rules. Part B or similar services under Part C will be estimated, based on 80% of Usual and Reasonable Charges for covered services or supplies without regard to Medicare deductibles and other coinsurance limits. The estimated Medicare benefits will be used to coordinate benefits. This could result in significant reduction or denial of the Plan benefits.

(4) **Medicare Part C (Medicare Advantage).** This integration will not apply when Medicare and a Medicare-sponsored Advantage Plans deny coverage due to its enrolled beneficiary's failure to abide by the HMO or Participating Provider Program requirements. This Plan will not cover the expenses for those services or supplies and Plan benefits will not be paid.

Allowable Fees for Medicare Integration Only Will be Based on the Following:

(1) If the Provider accepts Medicare assignment of benefits, the Allowable Fees will be the same fees allowed by Medicare.

(2) If the Provider does not accept Medicare assignment, the Allowable Fees will be based on the Usual and Reasonable Charges for Out-of-Network Providers, the Network allowance for Network Providers or the charges determined by Medicare limiting charge regulations, whichever is the lower charge.

(3) If the Provider provides services under a Medicare Private Contract Option, Allowable Fees will be based on the Usual and Reasonable Charges or the Network allowance, if applicable for services covered by this Plan.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amounts and the Provider's charges when that Provider accepts Medicare assignment. If a Provider does not accept assignment, a beneficiary cannot be billed for charges over the limiting charge established by Medicare for that service by that Provider. However, if services are provided under the Medicare Private Contract Option, the Provider's charges can exceed the Medicare allowable fees.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this Provision Applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. The Plan Administrator may, at its option, deny all charges or authorize conditional interim benefit payments for medical or dental expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's subrogation rights. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) cannot assign any rights against any Third Party or insurer without express written consent of the Plan; and

(3) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over <u>any</u> and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits Incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms: "Covered Person" means anyone covered under the Plan, including minor Dependents.

"Recover", "Recovered", "Recovery" or "Recoveries" means all monies paid to the Covered Person or his/her designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery From Another Plan Under Which the Covered Person is Covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to deny or make conditional payments, and to request reports on and approve of all settlements.

Plan Participant is a Trustee Over Plan Assets

(1) Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Participant understands that he/she is required to:

- **(a)** notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
- **(b)** instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
- **(c)** in circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
- **(d)** hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Offset

If timely repayment is not made, or the Plan Participant and/or his or her attorney fails to comply with any of the

requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the East Side Self-Funded PPO Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is East Side Union High School District, 830 North Capitol Avenue, San Jose, California 95133, telephone 408.347.5050. COBRA continuation coverage for the Plan is administered by East Side Union High School District, 801 North Capitol Avenue, San Jose, California 95133, telephone 408.347.5051. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There May be Other Options Available When You Lose Group Health Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can Become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner is not a Qualified Beneficiary. This gives the Domestic Partner and children the contractual rights outlined in this document, but does not extend statutory provisions to the Domestic Partner or child.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

A same-sex spouse is covered as a Qualified Beneficiary under federal law as of September 16, 2013.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA"), as amended, does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What Factors should be Considered When Determining to Elect COBRA Continuation Coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law.

If you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Are There Other Coverage Options Besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the Procedure for Obtaining COBRA Continuation Coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the Election Period and How Long Must it Last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preference Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks he/she and/or his/her family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) enrollment of the Employee in any part of Medicare; or

IMPORTANT:

For the other Qualifying Events (divorce, termination of Domestic Partnership or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person at the following address:

East Side Union High School District
830 North Capitol Avenue
San Jose, CA 95133

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost (if under your plan the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month)). If you or your Spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA Coverage Available if a Qualified Beneficiary has Other Group Health Plan Coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

(5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) **(i)** 29 months after the date of the Qualifying Event, or **(ii)** the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the Maximum Coverage Periods for COBRA Continuation Coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under What Circumstances Can the Maximum Coverage Period be Expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Sponsor.

How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled starting at some time before the 60th day of COBRA continuation coverage and lasting at least until the end of the 18-month period of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the later of the date of the determination, the date of the qualifying event, or the date coverage would have been lost due to the qualifying event, and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Administrator.

Does the Plan Require Payment for COBRA Continuation Coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for Payment for COBRA Continuation Coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Is COBRA Continuation Coverage Available to Domestic Partners and Children of Domestic Partners? A Domestic Partner is treated as a Qualified Beneficiary. This gives the Domestic Partner the contractual rights outlined in this document but does not extend statutory provisions to the Domestic Partner.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA). Visit the US Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1.866.444.3272.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. East Side Self-Funded PPO Plan is the benefit plan of East Side Union High School District, the Plan Administrator, also called the Plan Sponsor.

An individual may be appointed by East Side Union High School District to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, East Side Union High School District shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes that may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

(8) Ensure continuing compliance with the HIPAA Privacy and Security Regulation and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as amended.

Plan Administration Compensation. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY RESPONSIBILITIES: POMCO Administrators, as the Claims Administrator, is deemed the Claims fiduciary under the Plan. The health Plan remains the fiduciary for Plan Administration.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees. The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your Dependents or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

RECOVERING OVERPAYMENTS AND MISTAKEN PAYMENTS

In the event that a participant, beneficiary or a third party is paid benefits from the Plan in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter “overpayments” or “mistaken payments”), the Claims Administrator, on behalf of the Plan, has the right to start paying the correct benefit amount. In addition, the Claims Administrator, on behalf of the Plan, has the right to recover any overpayment or mistaken payment made to a claimant or to a third party. The claimant, third party, or other individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Claims Administrator, on behalf of the Plan, with interest at 12% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of the claimant or your Spouse or Dependents, by commencing a legal action or by such other methods as the Claims Administrator, on behalf of the Plan, determines to be appropriate. The claimant, third party, or other individual or entity shall reimburse the Claims Administrator, on behalf of the Plan, for attorneys’ fees and paralegal fees, court costs, disbursements, and any expenses Incurred in attempting to collect and in collecting the overpayment or mistaken payment of benefits.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

FEDERAL LAWS

This Plan shall be governed and construed according to Federal laws such as, but not limited to, the Public Health Service Act, as applicable, and the Health Insurance Portability and Accountability Act, as amended. Federal laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under this plan by contacting the closest Employee Benefits Security Administration (EBSA), US Department of Labor shown in your local phone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Ave. N.W., Washington, DC 20210.

HIPAA COMPLIANCE

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality, integrity, security and privacy of individually identifiable health information. A description of a Covered Person’s HIPAA Privacy rights are found in the Plan Administrator's Privacy Notice which is delivered separately to each Employee covered under the Plan. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan and those administering it agree to implement physical and technical safeguards that protect the information that it creates, receives, maintains or transmits on behalf of the Covered Person. If a Covered Person has a complaint,

questions, concerns, or requires a copy of the Privacy Notice, he or she should contact the Plan Administrator's Privacy Officer at the Employer.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees and Retired Employees. The Plan is not insured.

PLAN NAME: East Side Self-Funded PPO Plan

TAX ID NUMBER: 94-2864814

PLAN EFFECTIVE DATE: July 1, 2016

PLAN RESTATEMENT EFFECTIVE DATE: July 1, 2017

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION: East Side Union High School District
830 North Capitol Avenue
San Jose, CA 95133
408.347.5000

PLAN ADMINISTRATOR: East Side Union High School District
830 North Capitol Avenue
San Jose, CA 95133
408.347.5000

CLAIMS ADMINISTRATOR:

Health: POMCO Administrators
2425 James Street
Syracuse, NY 13206
1.844.344.8320

Prescription: ProAct
1226 US Highway 11
Gouverneur, NY 13642

BY THIS AGREEMENT, East Side Self-Funded PPO Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for East Side Union High School District on or as of the day and year first below written.

By______________________________________
East Side Union High School District

Date ___________________________________

Witness ________________________________

Date ___________________________________