Self-Insured Schools of California (SISC)
Self-Insured Schools of California Prudent Buyer Plan
HSA-$1500 FAM Rx HSA-$1500 FAM Option Benefit Booklet
Amendment No. 1

For the Summary Plan Description, which is effective October 1, 2023, the Self-Insured Schools of California (SISC) Prudent Buyer Plan, HSA-$1500 FAM Rx HSA-$1500 FAM Option hereby amends such document as of January 1, 2024 as follows:

Throughout the benefit booklet, DELETE:

HSA-$1500 FAM Rx HSA-$1500 FAM

And REPLACE with:

HSA-$1700 FAM Rx HSA-$1700 FAM

Under SECTION IV—SCHEDULE OF BENEFITS, L. Schedule of Medical Benefits - HSA-$1500 FAM Rx HSA-$1500 FAM Option, DELETE:

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts accumulate towards each other. *Co-insurance* does not apply to the *deductible*.		
Per *plan participant*	$3,000	
Per *family unit*	$3,000	

And REPLACE with:

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts accumulate towards each other. *Co-insurance* does not apply to the *deductible*.		
Per *plan participant*	$3,400	
Per *family unit*	$3,400	

Under SECTION IV—SCHEDULE OF BENEFITS, L. Schedule of Medical Benefits - HSA-$1500 FAM Rx HSA-$1500 FAM Option, DELETE:

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-insurance*, *deductibles*, and *prescription drugs*. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,000	Unlimited
Per *family unit*	$6,000	Unlimited

And REPLACE with:

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-insurance*, *deductibles*, and *prescription drugs*. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,400	Unlimited
Per *family unit*	$6,800	Unlimited

All other terms and conditions of this Self-Insured Schools of California (SISC) Prudent Buyer Plan which are not affected by this amendment remain unchanged.

Self-Insured Schools of California (SISC) hereby adopts the provisions of this amendment of the Self-Insured Schools of California (SISC) Prudent Buyer Plan, and its duly authorized officer has executed this amendment.

By: _____ Date: 3-14-24

Title: Director of Health Benefits

SISC

Self-Insured Schools of California

Schools Helping Schools

Self-Insured Schools of California (SISC)

Self-Insured Schools of California Prudent Buyer Plan

HSA-$1500 FAM, Rx HSA-$1500 FAM Option Benefit Booklet

Effective
October 1, 2023

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SECTION I—INTRODUCTION

This document is a description of the Self-Insured Schools of California (SISC) (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the benefit booklet. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

The *Plan Sponsor* and *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, *co-payments*, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under the *Patient Protection and Affordable Care Act (PPACA),* also known as Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

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 Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services, you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs.

Review your *Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

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 or after coverage terminates. 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 or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements. Refer to Quick Reference Information Chart for contact information.

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-379-4844.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-379-4844.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-379-4844.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-379-4844.

A. Quick Reference Information Chart

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator	Self-Insured Schools of California P.O. Box 1847 Bakersfield, CA 93303-1847 1-661-636-4410
Medical Claims Administrator/Third Party Administrator (Medical) • *Claim* Forms (Medical) • Medical *Claims* • First Level *Appeals* of Post-Service *Claims* • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-877-379-4844 **https:\\SISC.MyAmeriBen.com**
Medical Management Administrator • *Pre-Certification*, Concurrent Review, and Case Management • First Level *Appeals* of *Pre-Service Claims*	AmeriBen Medical Management P.O. Box 7186 Boise, ID 83707 1-877-379-4845
Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory – see website	Anthem 1-800-810-BLUE **www.anthem.com/ca/sisc**
Prescription Drug Program • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for *Non-Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail and Mail Order** Navitus Rx 1-866-333-2757 **www.navitus.com**
Employee Assistance Program (EAP) • EAP Counseling and Referral Services	Anthem EAP 1-800-999-7222 **www.anthemeap.com**
COBRA Administrator • Continuation Coverage	P.O. Box 966 Bakersfield, CA 93302 1-661-636-4410

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

The name, address, and telephone number of the *Plan Administrator* are:

Self-Insured Schools of California
P.O. Box 1847
Bakersfield, CA 93303-1847
1-661-636-4410EIN 77-0162263

An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* 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 (including the determination of what services, supplies, care, and treatments are *experimental/investigational*), 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* as to the facts related to any *claim* for benefits and the meaning and intent of any provision of the *Plan*, or its application to any *claim*, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *plan participant* is entitled to them.

Service of legal process may be made upon the *Plan Administrator*.

D. Duties of the Plan Administrator

The duties of the *Plan Administrator* are to:

1. administer the *Plan* in accordance with its terms
2. interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies, or omissions
3. decide disputes that may arise relative to a *plan participant's* rights
4. prescribe procedures for filing a *claim* for benefits and to review *claim* denials
5. keep and maintain the plan documents and all other records pertaining to the *Plan*
6. appoint a *Third Party Administrator* to pay *claims*
7. delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate

E. Amending and Terminating the Plan

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, as the settlor of the *Plan*, the *Plan Sponsor*, through its directors and officers, may, in its sole discretion, at any time, 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).

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that either:

1. the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents
2. the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in their own discretion

If the *Plan* is terminated, the rights of the *plan participant* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

F. Plan Administrator Compensation

The *Plan Administrator* serves without compensation; however, all expenses for *Plan* administration, including compensation for hired services, will be paid by the *Plan*.

G. Fiduciary Duties

A *fiduciary* must carry out their duties and responsibilities for the purpose of providing benefits to the *employees* and their *dependent(s)* and defraying *reasonable* expenses of administering the *Plan*. These are duties which must be carried out:

1. with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation
2. by diversifying the investments of the *Plan* so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so

H. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Third Party Administrator*. The *Plan* is not insured.

I. Plan Name

The name of the *Plan* is the Self-Insured Schools of California (SISC).

The *Plan* is commonly known as an employee welfare benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The Self-Insured Schools of California (SISC) is structured as an ERISA exempt plan under ERISA Section 4(b).

J. Plan Year

The *plan year* is the twelve (12) month period beginning October 1 and ending September 31.

K. Plan Effective Date

October 1, 2023

L. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* (*TPA*) to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-877-379-4844

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*, except to the extent otherwise agreed upon in writing.

M. Plan Sponsor or Employer's Right to Terminate

The *Plan Sponsor* or *employer* reserves the right to amend or terminate this *Plan* at any time. Although the *Plan Sponsor* or *employer* currently intends to continue this *Plan*, the *Plan Sponsor* or *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *Plan Sponsor* or *employer* will sign the documents with respect to such amendment or termination.

SECTION II—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

Eligible Classes of Employees

All *active employees* of the *employer*.

To enroll, or to enroll *dependents,* the *employee* must properly file an application with SISC. An application is considered properly filed, only if it is personally signed, dated, and given to SISC within thirty-one (31) days from your eligibility date. If any of these steps are not followed, coverage may be denied, or you may have to wait until the next open enrollment period to enroll.

Eligibility Requirements for Employee Coverage

A person is eligible for *employee* coverage from the first day that the *employee*:

1. is a full-time, *active employee* of the *employer*

   An *employee* is considered to be full-time if they normally work at least thirty (30) hours per week and are on the regular payroll of the *employer* for that work.

2. is a part-time, active *employee* of the *employer*

   Any *employee who* works at least twenty (20) hours per week is eligible to enroll. Any *employee who* works an average of thirty (30) hours per week as defined by federal law must be offered coverage. Any *employee* who works at least 90% of a forty (40) hour work week must enroll according to the SISC eligibility policy.

3. A classified non-temporary *employee* who works the minimum number of hours required by SISC and the *participating employer*.
4. A certificated *employee* under contract and who works a minimum of 50% of a certificated job.
5. A retired *employee* who retired from active employment and was covered under a *Plan* sponsored by SISC immediately prior to retirement.
6. is in a class eligible for coverage, as shown above

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* the first of the month (unless stated otherwise) following their eligibility date provided the *employee* satisfies all requirements as listed herein to become eligible.

Active Employee Requirement

An *employee* must be an active *employee* (as defined by this *Plan*) for this coverage to take effect.

Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term 'spouse' includes the person recognized as the covered *employee's* legally married husband or wife and shall not include common law marriages. The *Plan Administrator* may require documentation proving a legal marital relationship.

   The term 'spouse' does also include the person who is registered with the *employer* as the domestic partner of the *employee*; this includes opposite sex and same sex couples. An individual is a domestic partner of an *employee* if that individual and the *employee* meet each of the following requirements:

   a. both persons have a common residence
   b. both persons agree to be jointly responsible for each other's basic living expenses *incurred* during their domestic partnership
   c. neither person is married or a member of another domestic partnership
   d. the two (2) persons are not related by blood in a way that would prevent them from being married to each other in California
   e. both persons are at least eighteen (18) years of age.

f. Either of the following:

   i. both persons are members of the same sex

   ii. One (1) or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged members. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one (1) or both of the persons are over the age of sixty-two (62) and are registered with the State of California.

g. both persons are capable of consenting to the domestic partnership

h. Neither person has previously filed: (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction; or, if (1) does not apply, (2) an affidavit with SISC declaring they are part of a domestic partnership that they have not been terminated by giving SISC written notice that it has.

i. It has been at least six (6) months since:

   i. the date that the Notice of Termination of Domestic Partnership was filed with the California Secretary of State, or similar form was filed with another governing authority; or

   ii. either person has given written notice to SISC III that the domestic partnership they declared in an affidavit, given to SISC, has terminated. This item does not apply if the previous domestic partnership ended because one (1) of the partners died or married.

j. both partners:

   i. If they reside in the State of California, must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to Division 2.5 of the California Family Code to establish their domestic partnership. The *employee* must provide SISC with a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State

   ii. If they reside in another state or governing jurisdiction that registers domestic partnerships, they must register their domestic partnership with that state or governing jurisdiction. The *employee* must provide SISC with a certified copy of the document that was filed with the governing jurisdiction registering their domestic partnership

   iii. If the *employee* and their domestic partner do not reside in a city, county, or state that allows them to register as domestic partners, they must provide SISC with a signed, notarized, affidavit certifying they meet all of the requirements set forth above, inclusive.

NOTE: For the purposes of the above, if the *employee* and their domestic partner registered their relationship prior to July 1, 2000, with a local governing jurisdiction in California, in lieu of supplying SISC with a certified copy of the Declaration of Domestic Partnership (a State of California form), the *employee* may provide SISC with a certified copy of the form filed with the local governing jurisdiction.

To obtain more detailed information or to apply for this benefit, the *employee* must contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

In the event the domestic partnership is terminated, either partner is required to inform Self-Insured Schools of California of the termination of the partnership.

2. a covered *employee's* child(ren)

For the purposes of the *Plan*, an *employee's* child includes their:

a. natural child or stepchild

b. adopted child or a child placed with the *employee* for adoption

c. spouse's child

Unless otherwise specified, an *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. To determine when coverage will end for a child who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

The phrase 'placed for adoption' refers to a child whom a person intends to adopt, whether or not the adoption has become final, and who has not attained the age of eighteen (18) as of the date of such placement

for adoption. The term 'placed' means the assumption and retention by such person 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.

3. a covered *employee's* qualified *dependents*

   The term 'qualified *dependents*' shall include children for whom the *employee* is a *legal guardian*. The term 'qualified *dependents*' shall include the natural and adopted children of the *employee's* domestic partner. To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent* must be under the limiting age as described herein. To determine when coverage will end for a qualified *dependent* who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

   Any child of a *plan participant* who is an *alternate recipient* under a *Qualified Medical Child Support Order* (*QMCSO*) or National Medical Support Notice 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 *QMCSO* determinations from the *Plan Administrator*.

   The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. a covered *dependent* child or covered qualified *dependent* who reaches the limiting age and is *totally disabled*, incapable of self-sustaining employment by reason of mental or physical disability, primarily dependent upon the covered *employee* for support and maintenance, and is unmarried

   The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

   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.

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.

Ineligible Dependent(s)

Unless otherwise provided in this benefit booklet, the following are not considered eligible *dependents*:

1. other individuals living in the covered *employee's* home, but who are not eligible as defined
2. the divorced former spouse of the *employee*
3. grandchildren
4. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

If a *plan participant* 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 will be applied to maximums.

If two (2) *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.

Accumulators will transfer if a *dependent* changes from coverage under one parent *employee* to coverage under another parent *employee* as long as there is no lapse in coverage.

Eligibility Requirements for Dependent Coverage

A *dependent* 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, qualified *dependent,* or a child qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

B. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and/or their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

A newborn child will be automatically enrolled for thirty-one (31) days from birth. In order for coverage to continue, a covered *employee* must complete an enrollment application as shown in the Qualifying Events Chart subsection.

If the newborn child (and mother/covered parent) is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan* beyond the initial thirty-one (31) days from birth. The covered parent will be responsible for all further costs and will have to wait until the next *open enrollment period* to add the child as a *dependent*.

NOTE: Following delivery, grandchildren cannot be enrolled in the *Plan*. Refer to the **Ineligible Dependents** subsection for more details on individuals not eligible for enrollment under the *Plan*.

C. Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty-one (31) days after the person initially becomes eligible for coverage, or as shown in the Qualifying Events Chart subsection for each type of special enrollment period.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a 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 as shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration of a domestic partnership, adoption, or placement for adoption, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

E. Special Enrollment Periods

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

Individuals Losing Other Coverage, Creating a Special Enrollment Right

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if loss of eligibility for coverage meets any of the following conditions:

1. 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.
2. 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.
3. The coverage of the *employee* or *dependent* who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because *employer* contributions towards the coverage were terminated.
4. The *employee* or *dependent* requests enrollment in this *Plan* no later than as shown in the Qualifying Events Chart subsection after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of *employer* contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one (1) of the following occurs:

1. 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 (e.g., part-time *employees*).
2. 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, reduction in the number of hours of employment, or contributions towards the coverage were terminated.
3. 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).
4. 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.

Covered *employees* or *dependents* will not have a special enrollment right if the loss of other coverage results from either:

1. the *employee's* failure to pay premiums or required contributions
2. the *employee* or *dependent* making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the *Plan*

Dependent Beneficiaries

If a *dependent* becomes eligible to enroll and the *employee* is not enrolled, the *employee* must enroll in order for the *dependent* to enroll.

If both of the following conditions are met, then the *dependent* may be enrolled under this *Plan*:

1. The *employee* is a *plan participant* under this *Plan* (or has met the *waiting period* applicable to becoming a *plan participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period).
2. A person becomes a *dependent* of the *employee* through marriage, registration of a domestic partnership, birth, adoption, or placement for adoption.

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 is otherwise eligible for coverage. If the *employee* is not enrolled at the time of the event, the *employee* must enroll under this special enrollment period in order for their eligible *dependents* to enroll.

The *dependent* special enrollment period is as shown in the Qualifying Events Chart subsection. To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment during the timeframe specified as shown in the Qualifying Events Chart subsection.

F. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive.

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Marriage or registration of a domestic partnership	First of the month following the date of the event	thirty-one (31) days of marriage	
Divorce or annulment	First of the month following the date of the event	thirty-one (31) of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan

Birth of eligible child	First of the month following the date of the event	thirty-one (31) days of birth	
Adoption, placement for adoption, or legal guardianship of a child	First of the month following the date of the event	thirty-one (31) days of adoption	
Your *dependent* child reaches maximum age for coverage	First of the month following the date of the event	thirty-one (31) days of loss of eligibility	Coverage will terminate for the child who lost eligibility from your health coverage
Death of your spouse or *dependent* child	First of the month following the date of the event	thirty-one (31) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
Spouse or covered *dependent* obtains coverage in another group health plan	First of the month following the date of the event	thirty-one (31) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	First of the month following the date of the event	thirty-one (31) days of the date of loss of coverage	
Spouse's loss of coverage, including COBRA coverage	First of the month following the date of the event	thirty-one (31) days of the date of loss of coverage	Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	First of the month following the date of the event	thirty-one (31) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	First of the month following the date of the event	sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	First of the month following the date listed on the order	thirty-one (31) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Termination of Coverage

Rescission of Coverage

The *employer* or *Plan* has the right to rescind any coverage of the *employee* 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 *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 thirty (30) days' advance written *notice* of such action.

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):

1. If the *participation agreement* between the *participating employer* and the *Plan* terminates, the *employee's* coverage ends at the same time. Either the *participating employer* or the *Plan* may cancel or change the *participation agreement* without notice to *employees*.
2. If the *participating employer* no longer provides coverage for the class of *plan participants* to which the *employee* belongs, the *employee's* coverage ends when coverage for that class ends.
3. If the *employee* no longer meets the eligibility requirements established by the *Plan* in the *participation agreement*, the *employee's* coverage ends as of the next required monthly contribution due date. This is usually the first of the month.

   EXCEPTION: If required monthly contributions are paid, coverage may continue for an *employee* who is granted a temporary leave of absence up to six (6) months, a sabbatical year's leave of absence of up to twelve (12) months, or an extended leave of absence due to *illness* certified annually by the *participating employer*.
4. If required monthly contributions are not paid on the *employee's* behalf, the *employees'* coverage will end on the first day of the period for which required monthly contributions are not paid.
5. If less than full-time *employees* or *employees* who receive less than the amount contributed toward the cost of a full-time *employee* voluntarily cancel coverage, coverage ends on the first day of the month following a thirty (30) day notice.
6. **If** a retired *employee* does not elect coverage upon his or her retirement, coverage ends on the first day of the month immediately following his or her retirement date. If a retired *employee* declines district coverage, the retired *employee* may not elect coverage at a future date.

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**.

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):

1. If coverage for the *employee* ends, coverage for *dependents* ends at the same time
2. If coverage for *dependents* ceases to be available to the *employee, dependent's* coverage ends on that date.
3. If the *participating employer* fails to pay the required monthly contributions on behalf of a *dependent,* coverage ends on the last date for which the *participating employer* made this payment.
4. If a *dependent's* coverage is canceled, coverage ends on the first day of the month following a written notice within thirty-one (31) days of a qualifying event
5. If a *dependent* no longer meets the requirements set forth within, coverage ends on the first day of the month following that date.

   NOTE: If a child reaches the age limits as listed herein, the child will continue to qualify as a *dependent* if he or she is:

   a. covered under this *Plan*
   b. still chiefly dependent on the *employee, spouse*, or domestic partner for support and maintenance as defined by IRS rules
   c. incapable of self-sustaining employment due to a physical or mental condition.
   d. claimed as dependent on parents' income taxes with proof of most recently filed federal return

   A *physician* must certify in writing that the child has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. The *Plan* will notify the *employee* that the child's coverage will end when the child reaches the *Plan's* upper age limit at least ninety (90) days prior to the date the child reaches that age. The *employee* must send SISC proof of the child's physical or mental condition within sixty (60) days of the date the *employee* receives the request. When a period of two (2) years has passed, SISC may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than one (1) time each year. This exception will last until the child is no longer chiefly dependent on the *employee, spouse*, or domestic partner for support and maintenance or a physical or mental condition no longer exists. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a *dependent* for federal income tax purposes and actively claims the child as such.

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.**

NOTE: If a marriage or domestic partnership terminates, the *employee* must give or send to the *Plan* written notice of the termination. Coverage for a former *spouse* or *domestic partner,* if any, ends according to the provisions outlined herein. If the *Plan* suffers a loss as a result of the *employee* failing to notify them of the termination of their marriage or domestic partnership, the *Plan* may seek recovery from the *employee* for any actual loss resulting thereby. Failure to provide written notice to the *Plan* will not delay or prevent termination of the marriage or domestic partnership. If the *employee* notifies the *Plan Administrator* in writing to cancel coverage for a former *spouse* or *domestic partner* and the children of the *spouse* or *domestic partner,* if any, immediately upon termination of the *employee's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

H. 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.

During any leave taken under FMLA, 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*, coverage will be reinstated for the *employee* and their covered *dependents* if the *employee* returns to work in accordance with the terms of the *FMLA leave*. 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.

I. Continuation During Labor Dispute

If you are a *plan participant* who stops working because of a labor dispute, the *participating employer* may arrange for coverage to continue as follows:

1. **Required Monthly Contributions.** Required monthly contributions are determined by SISC as stated in the *participation agreement*. These required monthly contributions become effective on the required monthly contribution due date after work stops.
2. **Collection of Required Monthly Contributions.** The *participating employer* is responsible for collecting required monthly contributions from those *plan participants* who choose to continue coverage. The *participating employer* is also responsible for submitting required monthly contributions to SISC on or before each required monthly contribution due date.
3. **Cancellation if Participation Falls Below 75%.** SISC must receive premium for at least **75%** of *plan participants* who stop work because of the labor dispute. If at any time participation falls below **75%,** coverage may be cancelled. This cancellation is effective ten (10) days after written notice to the *participating employer*. The *participating employer* is responsible for notifying the *subscribers*.
4. **Length of Coverage.** Coverage during a labor dispute may continue up to six (6) months. After six (6) months, coverage is cancelled automatically without notice from SISC.

J. Continuation For Disabled District Members

If you become disabled as a result of a violent act directed at you while performing duties in the scope of employment as a district member, your benefits under this *Plan* may be continued.

1. **Eligibility.** You must be a member of the State Teachers' Retirement System or a classified school subscriber member of the Public Employees' Retirement System and be covered under the *participation agreement* at the time of the violent act causing the disability.
2. **Cost of Coverage.** The *participating employer* may require that you pay the entire cost of your continuation coverage. This cost (called the "required monthly contribution") must be remitted to the *participating employer* each month during your continuation. SISC must receive payment of the required monthly contribution each month from the *participating employer* in order to maintain the coverage in force. SISC will accept required monthly contributions only from the *participating employer*. Payment made by you directly to SISC will not continue coverage.

3. **When Continuation Coverage Begins.** When continuation coverage is elected and the required monthly contribution is paid, coverage is reinstated back to the date you became disabled, so that no break in coverage occurs, but only if you elect to continue coverage within sixty (60) days after your coverage terminates. For *dependents* acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of the *participation agreement*.
4. **When Continuation Coverage Ends.** This continuation coverage ends for the *plan participant* on the earliest of:
    a. the date the *participation agreement* terminates
    b. the end of the period for which required monthly contributions are last paid
    c. the date the maximum benefits of this *Plan* are paid

    For *dependents,* this continuation coverage ends according to the provisions as stated herein.

K. Coverage For Surviving Spouses of Certificated Members

If the *plan participant* dies while covered under this *Plan* as a certificated *plan participant* or a certificated retired *employee,* coverage continues for an enrolled spouse until one of the following occurs:

1. **The** spouse becomes covered under another group health plan
2. The spouse's coverage ends as described herein

EXCEPTION: If the *plan participant* dies while covered under this *Plan* as a classified *plan participant* or a classified retired *employee,* the enrolled spouse may be eligible to continue coverage under this benefit. Please consult your *participating employer* for details regarding their policy

L. Extension of Benefits

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

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

M. Rehiring a Terminated Employee

A terminated *employee* who is rehired will be eligible for coverage under the *Plan* the first day of the month following employment.

N. Open Enrollment

There is an open enrollment period once each year. This period of time is generally held during the month of August. During that time, an *employee* who meets the eligibility requirements under this *Plan* may enroll. An *employee* may also enroll any eligible *dependents* at that time.

For anyone so enrolling, coverage under this *Plan* will begin on the first day of October following the end of the open enrollment period. Coverage under the former plan ends when coverage under this *Plan* begins.

If the *Plan* has an active *open enrollment period*, a *plan participant* who fails to make an election will no longer be covered under this *Plan*. If the *Plan* has a passive *open enrollment period*, a *plan participant* will automatically retain their present coverages. However, if an *employee* is enrolled in an HSA or FSA, they are required to actively elect these benefits during the *open enrollment period* each year in order to retain their present coverage. *Plan participants* will receive detailed information regarding open enrollment from their *participating employer*.

SECTION III—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care providers which are called *network* providers. Because these *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.

Therefore, when a *plan participant* uses a *network* provider, that *plan participant* will receive better benefits from the *Plan* than when a *non-network* provider is used. It is the *plan participant's* choice as to which provider to use.

If a *plan participant* receives information with respect to an item or service from the *Plan*, its representative, or a database maintained by the *Plan* or its representative indicating that a particular provider is a *network* provider and the *plan participant* receives such item or service in reliance on that information, the *plan participant's co-insurance*, *co-payment*, *deductible*, and out-of-pocket maximum will be calculated as if the provider had been a *network* provider despite that information proving inaccurate.

Non-Network Provider Information

Non-network providers have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, *co-payments*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator* as outlined in the Quick Reference Information Chart.

Except as outlined in No Surprises Act, the charge billed by a *non-network* provider for any covered service is higher than the m*aximum allowable charge* determined by the *Plan*, *plan participants* are responsible for the excess unless the provider accepts *assignment of benefits* as consideration in full for services rendered. Since *network* providers have agreed to accept a negotiated discounted fee as full payment for their services, *plan participants* are not responsible for any billed amount that exceeds that fee. The *Plan Administrator* reserves the right to revoke any previously-given *assignment of benefits* or to proactively prohibit *assignment of benefits* to anyone, including any provider, at its discretion.

To receive benefit consideration, *plan participants* may need to submit claims for services provided by *non-network* providers to the *Third Party Administrator*. *Network* providers have agreed to bill the *Plan* directly, so that *plan participants* do not have to submit *claims* themselves.

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* 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 a *network* provider.

B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a *primary care physician* (*PCP*) to coordinate your care, and you do not have to obtain a referral to see a specialist.

You do not need prior authorization from the *Plan* or *Third Party Administrator*, or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the *network* who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access a *network* provider for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network* provider's care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

2. **No Choice of Provider.** If, while receiving treatment at a *network* facility and provider (other than from a surgeon in a non-emergency situation), a *plan participant* receives ancillary services or supplies from a *non-network* provider in a situation in which they have no control over provider selection (such as in the selection of an ambulance, emergency room *physician*, an anesthesiologist, assistant surgeon, or a provider for *diagnostic services*), such *non-network* services or supplies will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

3. **No Surprises Act – Emergency Services and Surprise Bills.** Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by state and/or federal entities directly impact actions and availability of the items described. For *non-network* claims subject to the No Surprises Act ("NSA"), *plan participant* cost sharing will be the same amount as would be applied if the *claim* was provided by a *network* provider and will be calculated as if the *Plan*'s *allowable charge* was the *recognized amount*, regardless of the *Plan*'s actual *maximum allowable charge*. The NSA prohibits providers from pursuing *plan participants* for the difference between the m*aximum allowable charge* and the provider's billed charge for applicable services, with the exception of valid *Plan*-appointed cost sharing as outlined above. Any such *cost sharing amounts* will accrue toward *in network deductible*s and *out-of-pocket limit* maximums.

   Benefits for *claims* subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial *claim*, and if approved will be paid directly to the provider. *Claims* subject to the NSA are those which are submitted for:

   a. emergency services

   b. non-emergency services rendered by a *non-network* provider at a *participating health care facility*, provided the *plan participant* has not validly waived the applicability of the NSA

   c. covered *non-network* air ambulance services

4. **Providers Outside of Network Area.** If *non-network* provider is used because the necessary specialty is not in the *network* or is not reasonably accessible to the *plan participant* due to geographic constraints [over fifty (50) miles from home], such *non-network* care will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

   Additional information about this option, as well as a list of *network* providers, will be given to *plan participants*, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

5. **Continuity of Care.** In the event a *plan participant* is a continuing care patient receiving a course of treatment from a *network* provider or otherwise has a contractual relationship with the *Plan* governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the *plan participant* shall have the following rights to continuation of care.

   The *Plan* shall notify the *plan participant* in a timely manner after termination of the provider's contractual relationship with the *Plan* and that the *plan participant* has rights to elect continued care from the provider. If the *plan participant* elects in writing to receive continued care, *Plan* benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the *Plan*'s notice of termination is provided and ending ninety (90) days later or when the *plan participant* ceases to be a continuing care patient, whichever is sooner.

   For purposes of this provision, "continuing care patient" means an individual who:

   a. is undergoing a course of treatment for a serious and complex condition from a specific provider,

   b. is undergoing a course of institutional or *inpatient* care from a specific provider

c. is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery

d. is pregnant and undergoing a course of treatment for the *pregnancy* from a specific provider

e. is or was determined to be terminally ill and is receiving treatment for such *illness* from a specific provider

Note that during continuation, although *Plan* benefits will be processed as if the termination had not occurred and the law requires the provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the *Plan* may be unable to protect the *plan participant* if the provider pursues a *balance bill*.

D. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call the *Claims Administrator* to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health Identification Card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 1-800-810-2583. Or you can call them collect at 1-804-673-1177.

If you need *inpatient hospital* care, you or someone on your behalf, should contact the *Claims Administrator* for *pre-certification* as outlined in the Quick Reference Information Chart. Keep in mind, if you need emergency medical care, go to the nearest *hospital*. There is no need to call before you receive care.

Please refer to the **Health Care Management Program** *pre-certification* provisions in this booklet for further information. You can learn how to get *pre-certification* when you need to be admitted to the *hospital* for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange *inpatient hospital* care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any *co-payment*, *co-insurance*, or *deductible* amounts that may apply.

You will typically need to pay for the following services up front:

1. doctor services
2. *inpatient hospital* care not arranged through Blue Cross Blue Shield Global Core
3. *outpatient* services

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms, you can get international claims forms in the following ways:

1. call the Blue Cross Blue Shield Global Core Service Center at the numbers above
2. online at **www.bcbsglobalcore.com** or **https:\\SISC.MyAmeriBen.com**

You will find the address for mailing the claim on the form.

E. Network Information

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website.

Anthem

1-800-810-BLUE

www.anthem.com/ca/sisc

All locations

SECTION IV—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-877-379-4844

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

B. Schedule of Benefits

All benefits described in the **Schedule of Benefits** 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*; those charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental/investigational*.

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 charges* and/or exclusions with specificity. If you have questions about specific supplies, treatments, or procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* may be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long term acute care facility (LTAC), not *custodial care*
    c. *skilled nursing facility*/rehabilitation facility
    d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

    The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
2. *inpatient* and *outpatient surgery* including pain management injections. Pain management injections in excess of $1,000 performed in an office setting also require *pre-certification*. All other office *surgeries* and screening colonoscopies do not require *pre-certification*.
3. bariatric surgical services, such as gastric bypass and other *surgical procedures* for weight loss, including bariatric travel expense, if:
    a. the services are to be performed for the treatment of *morbid obesity*
    b. the *physicians* on the surgical team and the facility in which the *surgical procedure* is to take place are approved for the *surgical procedure* requested
    c. the bariatric *surgical procedure* will be performed at a Blue Distinction (BD) or a Blue Distinction+ BD+) facility
4. *inpatient* hip replacement, knee replacement, or spine surgical services, including hip replacement, knee replacement, or spine *surgery* travel expenses, if:
    a. the services are to be performed for hip replacement, knee replacement, or spine *surgery*
    b. the *physicians* on the surgical team and the facility in which the *surgical procedure* is to take place are approved for the *surgical procedure* requested
    c. the hip replacement, knee replacement, or spine *surgical procedure* will be performed at a Blue Distinction+ (BD+) facility

5. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
6. behavioral treatment for pervasive developmental disorder or autism
7. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
8. dialysis
9. *durable medical equipment* (DME) in excess of $1,000 (purchase/rental price)
10. *gene therapy*
11. genetic/genomic testing (excluding amniocentesis)
12. *home health care services*
13. home infusion therapy or infusion therapy, if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
14. non-emergent air ambulance
15. orthotics/prosthetics in excess of $1,000 purchase price
16. *outpatient* advanced imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans (excluding services rendered in an emergency room setting)
17. physical therapy, physical medicine, occupational therapy, and chiropractic care in excess of five (5) visits per therapy type, per provider
18. partial hospitalization, intensive outpatient programs, and transcranial magnetic stimulation (TMS)
19. sleep studies/services
20. specialty infusion/injectable medications over $1,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

C. Deductible Amount

Deductibles are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *calendar year,* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

D. Benefit Payment

Each *calendar year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments,* and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

E. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *calendar year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*.

The *network out-of-pocket limit* includes applicable amounts paid for *deductibles*, *co-payments*, and *co-insurance* (including *non-participating* emergencies or ambulance services).

F. Diagnosis Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

1. the *Plan* will base their portion of the charge on the *network allowed amount*
2. the *plan participant's* portion of the charge will be based on the billed charges and will not exceed the billed charges
3. the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

G. Co-Insurance

For *covered charges incurred* with a *network* provider, the *Plan* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*. Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

H. Co-Payments

In certain cases, instead of paying *co-insurance*, you must pay a specific dollar amount, as specified in the applicable Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment* and is typically payable to the health care provider at the time services or supplies are rendered.

Unless otherwise stated in the applicable Schedule of Medical Benefits, *co-payments* are applied per provider.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-payments* apply toward satisfaction of the *out-of-pocket limit*.

I. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

Network providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for *balance bills* do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

J. High Deductible Health Plan (HDHP)

A qualified *high deductible health plan* (*HDHP*) with a *health savings account* (*HSA*) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

How This Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account* (*HSA*). You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow. Preventive care services are not subject to the *deductible*. These benefits are paid at 100%.

Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Third Party Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Third Party Administrator* to ensure your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Third Party Administrator* stating how much the negotiated payment amount is and the amount for which you are responsible.

K. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general, not have any other non-*HDHP* medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
3. not be enrolled in a general purpose health care flexible spending account (and your spouse may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a *dependent* on someone else's tax return

Qualified Medical Expenses

A partial list is provided in IRS Publication 502, available at **www.irs.gov**.

L. Schedule of Medical Benefits – HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts accumulate towards each other. *Co-insurance* does not apply to the *deductible*.		
Per *plan participant*	$3,000	
Per *family unit*	$3,000	
Family Unit - Embedded Deductible If you are enrolled in the family option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $3,000 *family unit* embedded *deductible*, and the individual *deductible* is $3,000, and your child *incurs* $3,000 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $3,000 has not been met yet.		
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and *prescription drugs*. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,000	Unlimited
Per *family unit*	$6,000	Unlimited
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balanced billed* charges 5. amounts paid by *plan participants* for *non-network* services		

Benefits shown as *co-payments* and *co-insurance* are listed for what the *plan participant* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Acupuncture	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays 50% of the maximum allowed amount.	**Calendar Year Maximum:** twelve (12) visits.
Advanced Imaging	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Non-Network Benefit Maximum:** $800 per test. Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Allergy Services			
Allergy Testing	10% *co-insurance*, after *deductible*	Not Covered	Serum is included.
Allergy Treatment	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Ambulance Service	$100 *co-payment*/trip then 10% *co-insurance*, after *deductible*		Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit. **Benefit Maximum:** $50,000 per trip for non-emergent air ambulance services when performed by a *non-participating provider*. Air, ground, and water ambulance are covered under the *Plan*. Interfacility transports are covered under the *Plan* as deemed *medically necessary* to the nearest accredited general *hospital* with adequate facilities for treatment or after a *plan participant* has been stabilized at a *non-network* facility and transport is needed to get to a *network* facility. Chartered flights are not covered. ***Pre-certification* is required for non-emergent air ambulance.** Failure to obtain pre-certification may reduce benefits.
Ambulatory Surgical Center	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Benefit Maximum**: limited to $350 per day for non-emergency admission at a *non-network* provider.

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Applied Behavioral Analysis (ABA) Services			
Testing/Evaluation	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Treatment	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Chemotherapy Drugs/Infusions and Radiation Treatments	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Chiropractic Treatment	10% *co-insurance*, after *deductible*	Not Covered	Includes all *medically necessary* services. Maintenance therapy is not covered. *Spinal manipulations* apply to the rendering provider's benefit level. Covered services are subject to *medical necessity* review in excess of five (5) visits. If the service is *medically necessary*, the service will be automatically authorized.
Diabetic Education	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Diabetic Shoes	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Calendar Year Maximum:** two (2) pairs.
Diagnostic Testing	10% *co-insurance*, after *deductible*	Not Covered	
Dialysis, Outpatient	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Non-Network Benefit Maximum:** $350 per visits. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Durable Medical Equipment	10% *co-insurance*, after *deductible*	Not Covered	***Pre-certification* is required** for *DME* in excess of $1,000 purchase/rental price. Failure to obtain pre-certification may reduce benefits.
Emergency Room	$100 *co-payment*/visit then 10% *co-insurance*, after *deductible*		

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Glasses or Contacts Following Cataract Surgery	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Benefit Maximum**: the first pair of contact lenses or eyeglasses when required as a result of a covered *medically necessary* eye *surgery*.
Hearing Services			
Hearing Aids	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Benefit Maximum:** $700 per *plan participant*, per twenty-four (24) month period. This maximum includes the hearing aids (monaural or binaural), ear mold(s), batteries, cords, and other ancillary equipment. Over-the-counter hearing aids in conjunction with prescription will be covered.
Hearing Exams (Non-Routine)	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	Services include visits for fitting, counseling, adjustments, and repairs for a one (1) year period after receiving covered hearing aids.
Home Health Care	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Calendar Year Visit Maximum:** one hundred (100) visits *network* and *non-network* providers combined. One (1) visit by a home health aide equals four (4) hours or less. **Non-Network Benefit Maximum:** $150 per day. ***Pre-certification* is required.** Failure to obtain *pre-certification* may reduce benefits.
Home Infusion	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Non-Network Benefit Maximum:** $600 per day. ***Pre-certification* is required.** Failure to obtain *pre-certification* may reduce benefits.
Hospice Care			
Hospice Care	0% *co-insurance*, *deductible* waived	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	Respite care limited to five (5) consecutive days per admission. *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months.
Bereavement Counseling	0% *co-insurance*, *deductible* waived	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Inpatient Hospital			
Physician Visits	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Non-Network Benefit Maximum:** $600 per day. *Inpatient* services and supplies provided for hip replacement, knee replacement, and spine *surgery* must be performed by a designated *Blue Distinction+ (BD+) hospital*. No coverage if *inpatient* services and supplies are provided by a *hospital* that is not designated as *Blue Distinction+ (BD+)*. Please refer to the Schedule of Blue Distinction Center+ (BD+) schedule of benefits for hip replacement, knee replacement, and spine *surgery* services covered under the *Plan*. Limited to the semi-private room rate when such semi-private room rate is available. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Room and Board	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Lab and X-Ray	10% *co-insurance*, after *deductible*	Not Covered	
LiveHealth Online	0% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	Telemedicine benefit provided through Anthem at **www.livehealthonline.com**.

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Maternity			
Office Visits	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Non-Network Benefit Maximum:** $600 per day. *Dependent* child *pregnancy* is covered.
All Other Services	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Labor and Delivery	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Mental Disorders & Substance Use Disorder			
Inpatient	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Office Visits	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Outpatient	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	***Pre-certification* is required for certain services within this category.** Failure to obtain pre-certification may reduce benefits.
Partial Hospitalization and Outpatient Intensive Day Treatment	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Office Visit			
Primary Care Physician	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	Includes home visits.
Specialist	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Orthotic Appliances/Foot Orthotics/Prosthetics	10% *co-insurance*, after *deductible*	Not Covered	**Calendar Year Maximum:** two (2) pairs of custom molded orthotics. An additional two (2) pairs will be considered post-*surgery* if *medically necessary*. ***Pre-certification* is required** for orthotics/prosthetics in excess of $1,000 purchase price. Failure to obtain pre-certification may reduce benefits.

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Outpatient Surgery	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	The following *outpatient surgeries* are subject to a benefit limit if performed in an *outpatient hospital* setting: **Arthroscopy Benefit Maximum:** $4,500 per procedure. Maximum does not apply if *surgery* is performed in an *ambulatory surgical center*. **Cataract Surgery Benefit Maximum:** $2,000 per procedure. Maximum does not apply if *surgery* is performed in an *ambulatory surgical center*. **Colonoscopy Benefit Maximum:** $1,500 per procedure. Maximum does not apply if *surgery* is performed in an *ambulatory surgical center*. **Upper GI Endoscopy with Biopsy Benefit Maximum:** $1,250 per procedure. Maximum does not apply if *surgery* is performed in an *ambulatory surgical center*. **Upper GI Endoscopy without Biopsy Benefit Maximum:** $1,000 per procedure. Maximum does not apply if *surgery* is performed in an *ambulatory surgical center*. Please refer to the **Medical Benefits** section, Covered Medical Charges, for further description of these *surgeries*. ***Pre-certification* is required** for *outpatient surgical procedures* Pain management injections in excess of $1,000 performed in an office setting also require *pre-certification*. All other office *surgeries* and screening colonoscopies do not require *pre-certification*. Failure to obtain pre-certification may reduce benefits.
Post Aural Therapy	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Retail Health Clinics	10% *co-insurance*, after *deductible*	*Deductible* applies, the *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Routine Newborn Care	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the covered employee's *deductible* and *out-of-pocket limit*.
Skilled Nursing Facility	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays ll billed amounts exceeding the maximum allowed amount.	**Calendar Year Visit Maximum:** one hundred fifty (150) days *network* and *non-network* providers combined. **Non-Network Benefit Maximum:** $600 per day. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Therapy Services			
Physical Therapy Occupational Therapy	10% *co-insurance*, after *deductible*	Not Covered	Following the first five (5) visits, all physical therapy and occupational therapy services are subject to *medical necessity* review. If the service is within the first five (5) visits per *plan participant*, per provider, the service will be automatically authorized.
Speech Therapy	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	
Cardiac Rehabilitation Pulmonary Rehabilitation	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Cardiac Rehabilitation Calendar Year Maximum:** thirty-six (36) visits office and *outpatient* facility visits combined. Following thirty-six (36) visits, additional visits are subject to *medical necessity* review and will be covered under the *Plan* if determined to be *medically necessary*. Cardiac rehabilitation is limited to phase one (1) and phase two (2).
Urgent Care	10% *co-insurance*, after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	

HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** or **www.hrsa.gov** Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.			
Routine Wellness Care	0% *co-insurance*, *deductible* waived	Not Covered	Services include routine physical exam, related labs and x-rays, immunizations, gynecological exam, pap smear, 2D and 3D mammograms, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) visit per adult *plan participant*. This maximum does not include the well woman visit. Preventive screening colonoscopies are subject to the dollar maximum as outlined in the Outpatient Surgery benefit if rendered in an *outpatient hospital* setting. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	0% *co-insurance*, *deductible* waived	Not Covered	**Benefit Maximum:** One (1) breast pump per pregnancy. Breastfeeding support, supplies, and counseling. Breast pumps purchased over the counter are not covered.
Contraceptive Services	0% *co-insurance*, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit Limitations:** Services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

M. Schedule of Blue Distinction Center Benefits – HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

The following Blue Distinction Center benefits are considered under the following benefit structure. If the *Plan* requires travel, *plan participant* may be eligible for additional travel benefits through the vendor, HealthBase. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for a further description and limitations of this benefit and any associated covered travel expenses or applicable limitations. Based upon *medical necessity,* certain procedures may be approved to be performed outside of a *Blue Distinction Center/Center of Excellence*. The *Blue Distinction Center/Center of Excellence* requirement does not apply (services will be covered at the applicable benefit level subject to all other *Plan* provisions) if:

1. *emergency* or urgent *surgery* is *medically necessary* to treat a recent fracture
2. *plan participants* that are under the age of eighteen (18)
3. additional complications are present such as cancer
4. the *plan participant* has primary coverage with *Medicare* or another carrier
5. the *plan participant* lives outside of California

COVERED SERVICES	NETWORK CENTER OF EXCELLENCE/BLUE DISTINCTION CENTER	NETWORK	NON-NETWORK	SPECIAL COMMENTS
Bariatric Surgery	10% *co-insurance,* after *deductible*	Not Covered	Not Covered	**Travel Benefit Maximum**: $3,000 per *surgery* for travel to a *Blue Distinction Center/Center of Excellence* or *Blue Distinction+ (BD+)* only. Limited to three (3) trips maximum – one (1) pre-operative trip, one (1) *surgery* trip, and one (1) post-operative trip if necessary. All other related services will pay at the applicable benefit level. Bariatric surgery services will be covered under the *Plan* at a *Blue Distinction Center/Center of Excellence* or *Blue Distinction+ (BD+) Center*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
Cornea Transplants	10% *co-insurance,* after *deductible*	10% *co-insurance,* after *deductible*	*Deductible* applies, then *plan participant* pays all billed amounts exceeding the maximum allowed amount.	**Travel Benefit Maximum**: $10,000 per transplant for travel to *Blue Distinction Centers/Center of Excellence* only. Travel will only be covered under the *Plan* when the *plan participant's* home is fifty (50) miles or more from the nearest *Blue Distinction Center/Center of Excellence*. All other related services will pay at the applicable benefit level. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
All Other Organ Transplants	10% *co-insurance,* after *deductible*	Not Covered	Not Covered	**Travel Benefit Maximum**: $10,000 per transplant for travel to a *Blue Distinction Center/Center of Excellence* only. Travel will only be covered under the *Plan* when the *plan participant's* home is fifty (50) miles or more from the nearest *Blue Distinction Center/Center of Excellence*. All other related services will pay at the applicable benefit level. **Donor Search Limitation:** $30,000 per transplant per *plan participant*. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

N. Schedule of Blue Distinction Center+ (BD+) Benefits – HSA-$1,500 FAM, Rx HSA-$1,500 FAM Option

The following *inpatient* hip replacement/knee replacement/spine surgery benefits are considered under the following benefit structure. If the *Plan* requires travel, *plan participant* may be eligible for additional travel benefits through the vendor, HealthBase. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for a further description and limitations of this benefit and any associated covered travel expenses or applicable limitations. Based upon *medical necessity,* certain procedures may be approved to be performed outside of a *Blue Distinction+ (BD+)* Center. The *Blue Distinction+ (BD+) Center* requirement does not apply (services will be covered at the applicable benefit level subject to all other *Plan* provisions) if:

1. emergency or urgent *surgery* is *medically necessary* to treat a recent fracture
2. *plan participants* that are under the age of eighteen (18)
3. additional complications are present such as cancer
4. the *plan participant* has primary coverage with *Medicare* or another carrier
5. the *plan participant* lives outside of California

COVERED SERVICES	NETWORK BLUE DISTINCTION+ (BD+) CENTER	ALL OTHER PROVIDERS	SPECIAL COMMENTS
Inpatient Hip Replacement/Knee Replacement/Spine Surgeries	10% *co-insurance,* after *deductible*	Not Covered	**Travel Benefit Maximum:** $6,000 per *surgery*. Travel will only be covered under the *Plan* when the *plan participant's* home is fifty (50) miles or more from the nearest hip replacement/knee replacement/spine *Blue Distinction+ (BD+) Center*. All other related services will pay at the applicable benefit level. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

SECTION V—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

A. Covered Medical Charges

Covered charges are the *maximum allowable 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.

1. **3D Mammograms.**
2. **Abortion.** Services, supplies, care, or treatment in connection with an elective abortion.
3. **Acupuncture.** The services of a *physician,* licensed for this treatment, for acupuncture treatment to treat a disease, *illness* or *injury*, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping, moxibustion, and acupuncture provided in lieu of anesthetic. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
4. **Advanced Imaging.** Charges for advanced imaging, including Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
5. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician*, or in the *physician's* office.
6. **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport you from the place where you are *injured* or stricken by *illness*, or for inter-facility transport, as deemed *medically necessary* treatment. Inter-facility transport is also available to a *network hospital* after you have been stabilized at a *non-network hospital*. Ambulance services are covered when one (1) or more of the following criteria are met:

   For ground ambulance, you are transported:

   a. from your home, or from the scene of an accident or medical *emergency* to a *hospital*
   b. between *hospitals,* including when you are required to move from a *hospital* that does not contract with the *network to* one (1) that does
   c. between a *hospital* and a *skilled nursing facility or* other approved facility

   For air or water ambulance, you are transported:

   a. from the scene of an accident or medical *emergency to* a *hospital*
   b. between *hospitals*, including when you are required to move from a *hospital* that does not contract with the *network to* one (1) that does
   c. between a *hospital* and another approved facility

   Non-*emergency* ambulance services are subject to *medical necessity* reviews. *Emergency* ground ambulance services do not require review. You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

   Coverage includes *medically necessary* treatment of an *illness* or *injury* by medical professionals from an ambulance service, even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of *plan participants* or a *physician* are not a covered service.

   Not covered ambulance services include, but are not limited to, trips to:

   a. a *physician's* office or clinic
   b. a morgue or funeral home

   Important Information About Air Ambulance Coverage

Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital than* the ground ambulance can provide, this *Plan* will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such as a *skilled nursing facility* or a *rehabilitation hospital*), or if you are taken to a *physician's* office or to your home.

Hospital to Hospital Transport

If you are being transported from one (1) *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats you cannot give you the medical services you need. Certain specialized services are not available at all *hospitals*. For example, burn care, cardiac care, trauma care, and critical care are only available at certain *hospitals*. For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *physician* prefers a specific *hospital* or *physician*.

Charges for services requested for a licensed ground, air, or water ambulance service, when the patient is not transported, will not be covered by the *Plan*. Services for chartered flights will not be covered by the *Plan*.

***Pre-certification* is required for non-emergent air ambulance.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

7. **Ambulatory Surgical Center.** Services and supplies provided by an *ambulatory surgical center* in connection with *outpatient surgery*. For the services of a *non-participating provider* facility only, the *Plan's* maximum payment is limited to as shown in the applicable Schedule of Medical Benefits each time you have *outpatient surgery* at an *ambulatory surgical center*.
8. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
9. **Applied Behavioral Analysis Therapy/Testing (ABA).** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
10. **Arthroscopy Services.** Services and supplies provided for *medically necessary* arthroscopy services by medical professionals in connection with *outpatient surgery*.

    There is no maximum limitation under the *Plan* when arthroscopy services are performed at *a participating provider ambulatory surgical center*. A maximum payment as shown in the applicable Schedule of Medical Benefits per arthroscopy procedure will apply to covered *outpatient hospital* services if the procedure is performed by a *participating provider* in an *outpatient hospital* setting.

    Covered *outpatient hospital* services performed by a *participating provider* will be subject to any applicable *deductibles*, *co-payments*, *co-insurance*, and any amount over the benefit maximum limitation as shown in the applicable Schedule of Medical Benefits.

    Exceptions for arthroscopy services to be performed in an *outpatient hospital* include the below. If any of the below exceptions are met, benefit maximums as outlined in the applicable Schedule of Medical Benefits (outpatient surgery) will not apply.

    Clinical Review Exception:

    a. *Plan participant* has severe extenuating comorbidities or complication risks that require *inpatient* healthcare team availability
    b. Provider anticipates over a twenty-three (23) hour observation stay
    c. No ambulatory *surgical center*s within thirty (30) miles of the *plan participant*'s home available to perform the specified *surgery* within sixty (60) days of ***pre-certification*** date

    Benefit Exception:

    No ambulatory *surgical center* able to perform the specified procedure located within thirty (30) miles of *plan participant's* home
11. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.
12. **Breast Cancer.** Services and supplies provided in connection with the screening for, diagnosis of and treatment for breast cancer whether due to *illness* or *injury*, including:

    a. diagnostic mammogram examinations in connection with the treatment of a diagnosed *illness* or *injury*. Routine mammograms will be covered initially under the *preventive care* services benefit.

b. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service,* BRCA testing will be covered under the preventive care services benefit.

c. mastectomy and lymph node dissection; complications from a mastectomy including lymphedema

d. reconstructive *surgery* of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy

e. breast prostheses following a mastectomy

This coverage is provided according to the terms and conditions of this *Plan* that apply to all other medical conditions.

13. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary,* provided services are rendered in a *medical care facility* as defined by this *Plan*.

    Coverage will be limited to phase one (1) and phase two (2). *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

14. **Cataract Surgery.** Services and supplies provided for *medically necessary* cataract *surgery* by medical professionals in connection with *outpatient surgery*.

    There is no maximum limitation under the *Plan* when cataract *surgery* is performed at a *participating provider ambulatory surgical center*. A maximum payment as shown in the applicable Schedule of Medical Benefits per procedure for cataract *surgery* will apply to covered *outpatient hospital* services if the procedure is performed by a *participating provider* in an *outpatient hospital* setting.

    Covered *outpatient hospital* services performed by a *participating provider* will be subject to any applicable *deductibles*, *co-payments*, *co-insurance*, and any amount over the benefit maximum limitation as shown in the applicable Schedule of Medical Benefits.

    Exceptions for cataract *surgery* to be performed in an *outpatient hospital* include the below. If any of the below exceptions are met, benefit maximums as outlined in the applicable Schedule of Medical Benefits (outpatient surgery) will not apply.

    Clinical Review Exception:

    a. *plan participant* has severe extenuating comorbidities or complication risks that require *inpatient* healthcare team availability

    b. provider anticipates over a twenty-three (23) hour observation stay

    c. no *ambulatory surgical center*s within thirty (30) miles of the *plan participant*'s home available to perform the specified *surgery* within sixty (60) days of ***pre-certification*** date

    Benefit Exception:

    no *ambulatory surgical center* able to perform the specified procedure located within thirty (30) miles of *plan participant's* home

    The *Plan's* maximum payment will not exceed the amount shown in the applicable Schedule of Medical Benefits for services or supplies provided by a *nonparticipating provider*.

    This benefit also includes the first pair of contact lenses or eyeglasses when required as a result of a covered *medically necessary surgery*. *Covered charges* for glasses or contacts following cataract *surgery* will be payable as shown in the applicable Schedule of Medical Benefits.

15. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

16. **Chiropractic.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

    The review process for chiropractic care will be managed by the *Medical Management Administrator*. The program is designed to assure that the services you receive are *medically necessary and* appropriate, and that your benefits are used to your best advantage.

    All chiropractic care, regardless of the provider type, will be submitted by your provider to the *Medical Management Administrator* for *medical necessity* review. If the service is within the first five (5) visits per *member,* per provider, the service will be automatically authorized. After five (5) visits, services provided by

participating providers may or may not be authorized as *medically necessary*. *Non-participating* providers are not covered.

Medical necessity review after the first five (5) visits is not required, however it is highly recommended. Services for chiropractic care are subject to *medical necessity* which allows providers and *plan participants* to know up front what will be covered. Benefits for physical medicine will not be covered if rendered by a *non-participating* provider. If authorization is not obtained, *claims* for chiropractic care will be reviewed upon receipt of the *claim*.

There is no limit on the number of covered visits for *medically necessary* chiropractic care. *Covered charges* for will be payable as shown in the applicable Schedule of Medical Benefits.

17. **Circumcision.** Circumcision for newborns from birth to six (6) months. After six (6) months, only *medically necessary* circumcisions will be covered.
18. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive *surgery* for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
19. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.
20. **Colonoscopy.** Services and supplies provided for *medically necessary* colonoscopy services by medical professionals in connection with *outpatient surgery*.

    There is no maximum limitation under the *Plan* when colonoscopy services are performed at a *participating provider ambulatory surgical center*. A maximum payment as shown in the applicable Schedule of Medical Benefits per procedure for colonoscopy services will apply to covered *outpatient hospital* services if the procedure is performed by a *participating provider* in an *outpatient hospital* setting.

    Covered *outpatient hospital* services performed by a *participating provider* will be subject to any applicable *deductibles*, *co-payments*, *co-insurance*, and any amount over the benefit maximum limitation as shown in the applicable Schedule of Medical Benefits.

    Exceptions for colonoscopy services to be performed in an *outpatient hospital* include the below. If any of the below exceptions are met, benefit maximums as outlined in the applicable Schedule of Medical Benefits (outpatient surgery) will not apply.

    Clinical Review Exception:

    a. *plan participant* has severe extenuating comorbidities or complication risks that require *inpatient* healthcare team availability
    b. provider anticipates over a twenty-three (23) hour observation stay
    c. no *ambulatory surgical center*s within thirty (30) miles of the *plan participant*'s home available to perform the specified *surgery* within sixty (60) days of ***pre-certification*** date

    Benefit Exception:

    no *ambulatory surgical center* able to perform the specified procedure located within thirty (30) miles of *plan participant's* home

    The *Plan's* maximum payment will not exceed **the amount** shown in the applicable Schedule of Medical Benefits for services or supplies provided by a *nonparticipating provider*. The maximum outlined in the applicable Schedule of Medical Benefits also applies to screening or preventive colonoscopy services.
21. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the *Preventive Care* provision of this *Plan*. Self-administered contraceptives (not over-the-counter), are covered **under** the prescription drug plan.
22. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* for the following oral *surgical procedures*:

    a. *emergency* repair due to *injury*
    b. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

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

23. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*. Diabetic education is designed to teach a *plan participant* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy. This benefit includes nutritional counseling. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
24. **Diabetic Shoes.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
25. **Diagnostic Testing.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
26. **Dialysis/Hemodialysis Treatment.** This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

    The following renal dialysis services are covered:

    a. *outpatient* maintenance dialysis treatments in an *outpatient* dialysis facility
    b. home dialysis
    c. training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting

    ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
27. **Durable Medical Equipment (DME).** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Repair, delivery, set up, and education charges pertaining to DME are covered under the *Plan*.

    Replacement of purchased equipment if either:

    a. the replacement is needed because of a change in your physical condition
    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    Maintenance and repairs needed due to misuse or abuse are not covered.

    The following items will be considered under the DME benefit:

    a. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.
    b. **Diabetic Equipment.** Includes insulin pumps and continuous glucose monitors.
    c. **Sleep Apnea Oral Devices.**

    ***Pre-certification* is required when the purchase/rental price is expected to exceed $1,000.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
28. **Family History.** Charges related to services provided with a diagnosis of family history, including as covered under applicable federal law.
29. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded. Includes custom molded foot orthotics limited to two (2) pair per *calendar year*. Two (2) additional custom molded foot orthotics will be covered under the *Plan* if *medically necessary* following a covered *surgery*. Non-custom molded foot orthotics are not covered.
30. **Gender.** Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *physician*. This coverage is provided according to the terms and conditions of the *Plan* that apply to all other covered medical conditions, including *medical necessity* requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, *medically necessary* services related to gender transition such as transgender *surgery*, psychotherapy, and vocal training.

Coverage is provided for specific services according to *Plan* benefits that apply to that type of service generally, if the *Plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender *surgery* would be covered on the same basis as any other covered, *medically necessary surgery*.

Inpatient admissions related to transgender *surgery* services are subject to *pre-certification* in order for coverage to be provided. Please refer to the **Health Care Management Program** section for information on how to obtain the proper reviews.

Transgender Travel Expenses

Certain travel expenses incurred in connection with an approved transgender *surgery*, when the *hospital* at which the surgery is performed is seventy-five (75) miles or more from your place of residence, provided the expenses are authorized in advance by the *Claims Administrator*. The *Plan's* maximum payment will not exceed $10,000 per transgender *surgery*, or series of *surgeries* (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one (1) companion:

a. ground transportation to and from the *hospital* when it is seventy-five (75) miles or more from your place of residence
b. coach airfare to and from the *hospital* when it is three hundred (300) miles or more from your residence
c. lodging, limited to one (1) room, double occupancy
d. other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

The *calendar year deductible* will not apply and no *co-payments* will be required for transgender travel expenses authorized in advance by the *Claims Administrator*. Benefits will be provided for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amounts specified above. This travel expense benefit is not available for non-*surgical* transgender services.

31. **Gene Therapy.** Your *Plan* includes benefits for gene therapy services, when the *Claims Administrator* approves the benefits in advance through *pre-certification*. See the **Health Care Management Program** section for details on the *pre-certification* process. To be eligible for coverage, services must be *medically necessary* and performed by an approved *physician* at an approved treatment center. Even if a *physician* is a *participating provider* for other services it may not be an approved provider for certain gene therapy services. Please call the *Claims Administrator* to find out which providers are approved *physicians*. ***Pre-certification*** **is required.** Failure to obtain pre-certification may reduce benefits.
32. **Genetic/Genomic Testing and Counseling.** Genetic and genomic testing to identify the potential for, or existence of, a medical condition. Testing for amniocentesis is also covered. Genomic testing to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Genetic/genomic testing and counseling will be covered under the *Plan* when *medically necessary*. Refer to the **Federal Notices** section for the statement of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA). ***Pre-certification*** **is required (excluding amniocentesis).** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
33. **Hearing Aids.** Charges for services, supplies, and hearing exams in connection with hearing aids (including batteries), including, but not limited to, exams for their fitting. Over-the-counter hearing aids when obtained with a prescription from a *physician* will be covered under the *Plan*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
34. **Hearing Exams (Non-Routine).** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
35. **Hearing Exams (Routine).**
36. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* 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*.
    a. Benefit payment for nursing, home health aide, and therapy services are subject to the home health care limit shown in the applicable Schedule of Medical Benefits.

b. A home health care visit will be considered a periodic visit by a *physician* acting within the scope of their license and/or as defined under *home health care services*.

c. services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy

d. services of a medical social service worker

e. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in above. Other organizations may give services only when approved by the *Claims Administrator,* and their duties must be assigned and supervised by a professional nurse on the staff of the *home health agency* or other provider as approved by the *Claims Administrator*.

f. *medically necessary* supplies provided by the *home health agency*

g. When available in your area, benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home.

***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

37. **Home Infusion Therapy.** Home infusion therapy does not apply to the home health care maximum. The following services and supplies when provided in your home by a *home infusion therapy provider* or in any other *outpatient* setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to parenteral therapy and total parenteral nutrition (TPN), medication related to *illness* or *injury*, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

    a. medication, ancillary medical supplies and supply delivery, [not to exceed a fourteen (14) day supply]. However, medication which is delivered, but not administered is not covered.

    b. pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications

    c. *hospital* and home clinical visits related to the administration of infusion therapy, including *skilled nursing services* including those provided for:

        i. patient or alternative caregiver training

        ii. visits to monitor the therapy

    d. rental and purchase charges for *durable medical equipment* including maintenance and repair charges for such equipment. Benefits for *durable medical equipment* will not be covered if rendered by a *non-participating* provider

    e. laboratory services to monitor the *plan participant's* response to therapy regimen. Benefits for laboratory services will not be covered if rendered by a *non-participating* provider.

    f. total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous)

    The *Plan's* maximum payment will not exceed **the amount** shown in the applicable Schedule of Medical Benefits for services or supplies provided by a *nonparticipating provider*.

    ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

38. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

39. **Hospice Care.** *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months. Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally ill and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and *medically necessary* treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:

a. interdisciplinary team care with the development and maintenance of an appropriate plan of care

b. short-term *inpatient hospital care* when required in periods of crisis or as respite care. Coverage of *inpatient* respite care is provided on an occasional basis and is limited to a maximum of five (5) consecutive days per admission.

c. *skilled nursing services* provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

d. social services and counseling services provided by a qualified social worker

e. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

f. physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist

g. volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member

h. pharmaceuticals, medical equipment, and supplies necessary for the management of your condition

i. oxygen and related respiratory therapy supplies

j. palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the *illness*

k. bereavement counseling services for the *plan participant's* immediate family (covered spouse and/or other covered *dependents*)

A licensed pastoral counselor will be considered a covered provider for purposes of bereavement counseling, subject to all other *Plan* provisions.

NOTE: Bereavement counseling in connection with the *Plan's hospice care services* does **not** require *pre-certification*.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice must* submit a written treatment plan to the *Claims Administrator* every thirty (30) days.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a *plan participant* in *hospice*. These services are covered under other parts of this *Plan*.

Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

40. **Hospital Care.** The medical services and supplies furnished by a *hospital*, *ambulatory surgical facility*, or a *birthing center*. *Covered charges* for *room and board* will be payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for inpatient admissions.** Failure to obtain pre-certification may reduce benefits.

a. *Room and board* charges made by a *hospital* having only private rooms will be paid at the semi-private room rate when such semi-private room rate is available.

b. Charges for an *intensive care unit* stay do not apply to the semi-private room rate.

c. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services are covered for dental procedures if *medically necessary* and if any of the following conditions apply:

i. The *plan participant* is under age seven (7).

ii. The *plan participant* is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.

iii. The *plan participant* has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*.

Hip replacement, knee replacement, or spine *surgical procedures* when rendered on an *inpatient* basis are only covered under the *Plan* when be performed at a Blue Distinction+ (BD+) facility. This requirement would not apply to *plan participants* that meet the outlined exception criteria. If the outlined criteria is met, *plan participants* would receive services at the applicable benefit level. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for details on coverage under the *Plan*.

This benefit does not cover the *dentist's* services.

41. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for organic impotence, based on *medical necessity*.

42. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

43. **LiveHealth Online.** Telemedicine benefit provided through Anthem at **www.livehealthonline.com**. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

44. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. *Dependent* child *pregnancy* is covered. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*. Charges for a planned home birth will be considered a covered benefit.

    NOTE: Breastfeeding support, counseling, maintenance, breast milk storage supplies, pump parts, and other supplies are also available without cost sharing when services are received from a *network* provider.

    Pregnancy tests are not considered *preventive care* even when performed in conjunction with covered birth control services. Visit **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** for a current listing of required *pregnancy* related *preventive care* benefits.

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

45. **Medical Foods.** Medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary*. Medical foods taken orally are **not** covered under the *Plan*, except for PKU formula when *medically necessary*.

46. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces, unless covered under the *prescription drug* plan. Jobst/compression stockings are limited to four (4) pairs, or eight (8) units, per *plan participant* per *calendar year*.

47. **Mental Disorders and Substance Use Disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. The following services are covered under the *Plan:*

    a. *applied behavioral analysis* (*ABA*) therapy
    b. behavioral treatment for pervasive developmental disorder or autism delivered at home
    c. chat therapy, when available
    d. counseling (marital/pre-marital counseling, family counseling, and group counseling) when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined
    e. drug therapy monitoring
    f. *inpatient hospital* services from a *residential treatment center* (including crisis residential treatment)
    g. intensive in-home behavioral health services, when available
    h. intensive *outpatient* programs
    i. medical treatment for withdrawal symptoms
    j. methadone maintenance treatment
    k. multidisciplinary treatment in an intensive *outpatient* psychiatric treatment program
    l. nutritional counseling for the treatment of eating disorders such as anorexia nervosa and nervosa
    m. online visits, when available
    n. psychiatric day treatment
    o. partial hospitalization

p. residential treatment

Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

***Pre-certification* is required for inpatient admissions, partial hospitalization, intensive outpatient programs, and transcranial magnetic stimulation (TMS).** Failure to obtain pre-certification may reduce benefits.

Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008*.

48. **Methadone Assisted Treatment (MAT).**
49. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of their license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.
50. **Morbid Obesity.** Coverage is limited to counseling required prior to a *morbid obesity surgical procedure*. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for details on coverage under the *Plan* for bariatric *surgery*.
51. **National Health Emergency.** In the event of a declared National Health Emergency, the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health emergency, as required by federal regulation. The *Plan* will also cover medications authorized for emergency use by the appropriate federal agencies in the event of a public health emergency. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.
52. **Neuropsychological/Psychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.
53. **Obesity.** Coverage is limited to counseling for a diagnosis of obesity. Refer to the Medical Plan Exclusions for services not covered under the *Plan*.
54. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a *covered charge* under this *Plan* only if that care is for the following oral *surgical procedures*:
    a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth
    b. excision of benign bony growths of the jaw and hard palate
    c. external incision and drainage of cellulitis or soft tissue, not including odontogenic cysts or abscesses
    d. treatment of non-dental lesions
    e. incision of sensory sinuses, salivary glands, or ducts
    f. removal of all teeth at an *inpatient* or *outpatient hospital* or *dentist*'s office if removal of the teeth is part of standard medical treatment that is required before the *plan participant* can undergo radiation therapy for a covered medical condition
    g. organ transplant preparation
    h. removal of bony impacted teeth

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.
55. **Orthognathic Surgery.** Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

    NOTE: If a *plan participant* decides to receive dental services that are not covered under this *Plan,* a *participating provider* who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *Plan,* please call the number listed on your ID card. To fully understand your coverage under this *plan,* please carefully review this document.

56. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as cranial helmets, 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 *illness*. Benefits for repair or replacement of an orthotic appliance due to normal use, adolescent growth, or pathological changes will be provided. ***Pre-certification* is required when the purchase price is expected to exceed $1,000.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

57. **Osteoporosis.** Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed *medically necessary*.

58. **Outpatient Observation Stays.** Services for *outpatient* observation stays will be considered at the applicable benefit level.

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

    a. nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters

    b. education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the *Plan's* benefits for office visits to a *physician*.

60. **Pervasive Developmental Disorder (Autism).** This *Plan* provides coverage for behavioral health treatment for pervasive developmental disorder or autism. This coverage is provided according to the terms and conditions of this *Plan* that apply to all other medical conditions, except as specifically stated herein.

    Behavioral health treatment services covered under this *Plan* are subject to the same *deductibles*, *co-insurance*, and *co-payments* that apply to services provided for other covered medical conditions. Services provided by *qualified autism service providers*, *qualified autism service professionals*, and *qualified autism service paraprofessionals* will be covered under *Plan* benefits that apply for *outpatient* office visits or other *outpatient* items and services. Services provided in a facility, such as the *outpatient* department of a *hospital*, will be covered under *Plan* benefits that apply to such facilities.

    The behavioral health treatment services covered by this *plan* for the treatment of pervasive developmental disorder or autism are limited to those professional services and treatment programs, including *applied behavior analysis* and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following requirements:

    a. the treatment must be prescribed by a licensed *physician* or developed by a licensed psychologist

    b. The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one (1) of the following: (a) *qualified autism service provider*, (b) *qualified autism service professional* supervised and employed by the *qualified autism service provider*, or (c) *qualified autism service paraprofessional* supervised and employed by a *qualified autism service provider*

    c. The treatment plan must have measurable goals over a specific timeline and be developed and approved by the *qualified autism service provider* for the specific patient being treated. The treatment plan must be reviewed no less than once every six (6) months by the *qualified autism service provider* and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of *applied behavioral analysis* services and intensive behavioral intervention services to certain persons pursuant to which the *qualified autism service provider* does all of the following:

        i. describes the patient's behavioral health impairments to be treated

        ii. designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported

        iii. provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism

        iv. discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate

        v. The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating

in the treatment program. The treatment plan must be made available to the *Claims Administrator* upon request.

61. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the surgeon's *maximum allowable charge*.

    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 (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; *maximum allowable charge* will be allowed for each additional procedure performed 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 (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

    c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the *maximum allowable amount*, dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan,* unless *medically necessary*.

62. **Post Aural Therapy.** Therapy must follow *surgery* for a covered implantable hearing device. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

63. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. You should make sure your *hospital* will accept the results of these tests.

64. **Preventive Care.** Benefits will be provided for *preventive care,* including, but not limited to:

    a. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**

    b. **Colorectal Cancer Screening.**

    c. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the medical benefits of this *Plan*. Self-administered contraceptives are covered under the Prescription Drug Benefits.

    d. **Gynecological Exam.**

    e. **Mammogram.**

    f. **Pap Smear.**

    g. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC), including, but not limited to:

        i. **HPV Vaccine.** For male and female *plan participants* ages nine (9) through forty-five (45).

        ii. **Influenza Vaccine.**

        iii. **Shingles Vaccine.** For *plan participants* age fifty (50) and over.

    The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

    h. **Preventive Lab and X-Ray.** Laboratory and x-ray services related to routine examinations.

    i. **Sterilization.** Services for tubal ligation or other voluntary sterilization procedures for female *plan participants*.

NOTE: Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at the following websites:

a. **https://www.healthcare.gov/coverage/preventive-care-benefits/**

b. **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**

65. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis, but not replacement of such items unless the attending *physician* indicates *medical necessity* due to a change in the body condition, and the artificial limb or eye cannot be repaired or made serviceable.

    The following devices will be considered under the prosthetic benefit:

    a. **Implantable Hearing Devices.** Includes cochlear implants and bone anchored devices.

    b. **Mastectomy Bras and Camisoles.**

    c. **TMJ Oral Devices.**

    ***Pre-certification* is required when the purchase price is expected to exceed $1,000.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

66. **Pulmonary Rehabilitation.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

67. **Reconstructive Surgery.** Reconstructive *surgery* expenses are covered in the following circumstances:

    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part

       Surgical services must be initiated for *plan participants* before the age of nineteen (19).

    b. to correct damage caused by an *accidental injury*

    c. for breast reconstruction following a total or partial *mastectomy*, as follows:

       i. reconstruction of the breast on which the *mastectomy* has been performed

       ii. *surgery* and reconstruction of the other breast to produce a symmetrical appearance

       iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

    All other reconstructive *surgeries* will be covered under the *Plan* when *medically necessary*, except as otherwise excluded herein.

    Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

68. **Retail Health Clinics.** Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

    a. exams for minor *illnesses* and *injuries*

    b. preventive services and vaccinations

    c. health condition monitoring and testing

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

69. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

    a. This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:

       i. is a *plan participant* who was covered under the *Plan* at the time of the birth

       ii. enrolls (as well as the newborn child if required) in accordance with the Special Enrollment Periods provisions with coverage effective as of the date of birth

    b. The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.

70. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many

cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.

71. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:

    a. The patient is confined as a bed patient in the facility.

    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.

    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*.

    ***Pre-certification* is required for inpatient admissions.** Failure to obtain pre-certification may reduce benefits. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

72. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders when *medically necessary*. Coverage under the *Plan* includes sleep studies in the home. ***Pre-certification* is required.** Failure to obtain pre-certification may reduce benefits.

73. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the *Preventive Care* provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

74. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required for outpatient surgical procedures including pain management injections in excess of $1,000 (excluding all other office surgeries and screening colonoscopies).** Failure to obtain pre-certification may reduce benefits.

    Hip replacement, knee replacement, or spine *surgical procedures* when rendered on an *inpatient* basis are only covered under the *Plan* when be performed at a Blue Distinction+ (BD+) facility. This requirement would not apply to *plan participants* that meet the outlined exception criteria. If the outlined criteria is met, *plan participants* would receive services at the applicable benefit level. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for details on coverage under the *Plan*.

75. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of *temporomandibular joint* disorders.

76. **Therapy Services.** Services include physical therapy/physical medicine, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis. Therapy in the home applies to the *outpatient* maximum. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

    a. **Occupational Therapy**. Covered when provided on an *outpatient* basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, *illness* or *injury* including programs which are designed to rehabilitate mentally, physically, or emotionally handicapped *participants*. Occupational therapy programs are designed to maximize or improve a *plan participant's* upper extremity function, perceptual motor skills, and ability to function in daily living activities. Therapy must result from an *injury*, *illness,* and/or congenital condition and improve a body function. *Covered charges* do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

    b. **Physical Therapy/Physical Medicine.** Covered when provided on an *outpatient* basis for the treatment of *illness* or *injury*, including the therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists, and osteopaths). Coverage does not include massage therapy services at spas or health clubs. Benefits include aquatic therapy. The therapy must be for conditions which are subject to significant improvement through short-term therapy.

    Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other *outpatient* setting, during which one (1) or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

    Outpatient visits will require *medical necessity* review after the first five (5) visits per *calendar year*. Visits are counted on an annual basis per *plan participant* per provider office.

The review process for occupational therapy will be managed by the *Medical Management Administrator*. The program is designed to assure that the services you receive are *medically necessary* and appropriate, and that your benefits are used to your best advantage. All occupational therapy, regardless of the provider type, will be submitted by your provider to the *Medical Management Administrator* for *medical necessity* review. If the service is within the first five (5) visits per *plan participant*, per provider, the service will be automatically authorized. After five (5) visits, services provided by *participating providers* may or may not be authorized as *medically necessary*. *Non-participating* providers are not covered.

All physical therapy and physical medicine, regardless of the provider type, will be submitted for *medical necessity* review. If the service is within the first five (5) visits per *plan participant*, per provider, the service will be automatically authorized. After five (5) visits, services provided by *participating providers* may or may not be authorized as *medically necessary*. The *Medical Management Administrator* will review physical therapy/physical medicine. *Non-participating* providers are not covered.

Benefits for physical medicine will not be covered if rendered by a *non-participating* provider. If authorization is not obtained, *claims* for physical therapy, physical medicine, and occupational therapy will be reviewed upon receipt of the *claim*.

There is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, and occupational therapy.

c. **Speech Therapy**. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment. Therapy must follow either:

   i. *surgery* for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person

   ii. an *injury*

   iii. an *illness*

   iv. congenital condition

Rehabilitation Services. The *Plan* covers rehabilitation services to help a *plan participant* achieve a previous level of function, independence, and quality of life. Maintenance therapy is not covered for rehabilitative services.

Habilitation Services. The *Plan* covers *habilitation services* that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. Maintenance therapy is not covered for habilitative services.

Refer to the Medical Plan Exclusions, Habilitation Services, for further explanation on what is not covered under the *Plan*.

77. **Urgent Care.** Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not *emergency services*. Services for *urgent care* are typically provided by an *urgent care center* or other facility such as a *physician's* office. *Urgent care* can be obtained from *participating providers* or *non-participating providers*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

78. **Upper GI Endoscopy.** Services and supplies provided for *medically necessary* upper GI endoscopy services by medical professionals in connection with *outpatient surgery*.

There is no maximum limitation under the *Plan* when upper GI endoscopy services are performed at a *participating provider ambulatory surgical center*. A maximum payment as shown in the applicable Schedule of Medical Benefits per procedure for upper GI endoscopy services will apply to covered *outpatient hospital* services if the procedure is performed by a *participating provider* in an *outpatient hospital* setting.

Covered *outpatient hospital* services performed by a *participating provider* will be subject to any applicable *deductibles*, *co-payments*, *co-insurance*, and any amount over the benefit maximum limitation as shown in the applicable Schedule of Medical Benefits.

Exceptions for upper GI endoscopy services to be performed in an *outpatient hospital* include the below. If any of the below exceptions are met, benefit maximums as outlined in the applicable Schedule of Medical Benefits (outpatient surgery) will not apply.

Clinical Review Exception:

a. *plan participant* has severe extenuating comorbidities or complication risks that require *inpatient* healthcare team availability

b. provider anticipates over a twenty-three (23) hour observation stay

c. no ambulatory *surgical center*s within thirty (30) miles of the *plan participant*'s home available to perform the specified *surgery* within sixty (60) days of ***pre-certification*** date

Benefit Exception:

no ambulatory *surgical center* able to perform the specified procedure located within thirty (30) miles of *plan participant's* home

79. **Upper GI Endoscopy with Biopsy.** Services and supplies provided for *medically necessary* upper GI endoscopy with biopsy services by medical professionals in connection with *outpatient surgery*. There is no maximum limitation under the *Plan* when upper GI endoscopy with biopsy services are performed at a *participating provider ambulatory surgical center*. A maximum payment as shown in the applicable Schedule of Medical Benefits per procedure for upper GI endoscopy with biopsy services will apply to covered *outpatient hospital* services if the procedure is performed by a *participating provider* in an *outpatient hospital* setting.

    Covered *outpatient hospital* services performed by a *participating provider* will be subject to any applicable *deductibles*, *co-payments*, *co-insurance*, and any amount over the benefit maximum limitation as shown in the applicable Schedule of Medical Benefits.

    Exceptions for upper GI endoscopy with biopsy services to be performed in an *outpatient hospital* include the below. If any of the below exceptions are met, benefit maximums as outlined in the applicable Schedule of Medical Benefits (outpatient surgery) will not apply.

    Clinical Review Exception:

    a. *plan participant* has severe extenuating comorbidities or complication risks that require *inpatient* healthcare team availability

    b. provider anticipates over a twenty-three (23) hour observation stay

    c. no *ambulatory surgical center*s within thirty (30) miles of the *plan participant*'s home available to perform the specified *surgery* within sixty (60) days of ***pre-certification*** date

    Benefit Exception:

    no *ambulatory surgical center* able to perform the specified procedure located within thirty (30) miles of *plan participant's* home

80. **Virtual Visits.** When available in your area, covered services will include medical consultations using the internet via webcam, voice, or *chat therapy*. Virtual visits are covered under *Plan* benefits for office visits to *physicians*.

    The following services are not covered under the *Plan* when performed as part of a virtual visit:

    a. reporting normal lab or other test results

    b. office visit appointment requests or changes

    c. billing, insurance coverage, or payment questions

    d. requests for referrals to other *physicians* or healthcare practitioners

    e. benefit *pre-certification*

    f. consultations between *physicians*

81. **Vision Benefits.** Benefits are available for vision examinations, including refraction, when performed in conjunction with a medical diagnosis.

82. **X-Rays.** Diagnostic x-rays. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

B. Medical Plan Exclusions

The following list is intended to give you a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

1. **Adoptive Cell Therapy.**
2. **Aids for Non-Verbal Communication.** Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by the *Claims Administrator*.
3. **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.
4. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupressure, aromatherapy, hypnotism, massage therapy (except when rendered as part of *medically necessary* physical therapy/physical medicine or chiropractic care), rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
5. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
6. **Athletic Training.**
7. **Autopsies.** Autopsies and post-mortem testing.
8. **Biofeedback.**
9. **Cardiac Rehabilitation.** Cardiac rehabilitation phase three (3) and phase four (4).
10. **Chartered Flights.**
11. **Chelation Therapy.** Except for lead poisoning.
12. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more *participating providers* do participate in the *approved clinical trial*, the qualified *plan participant* must participate in the *approved clinical trial* through a *participating*, *network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
13. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*.
14. **Cord Blood.** Harvesting and storage of umbilical cord blood or except as required as part of a covered transplant procedure.
15. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent *surgery* related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*.
16. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling provided by *plan participant's* friends, *employer*, school counselor, or school teacher. This exclusion applies except as noted herein.
17. **Custodial Care/Rest Cures.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
18. **Dental Care.** Normal dental care benefits, including any dental, gum treatments, or oral *surgery* except as otherwise specifically provided herein.
19. **Diabetic Supplies.** Diabetic supplies are covered through the prescription drug benefits program.

20. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services such as nutrition therapy (except as stated herein), asthma self-management education (except as stated herein), and Lamaze.
21. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (including sports physicals) or professional or other licenses, except as required under applicable federal law.
22. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or limit, charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
23. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
24. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this plan document.
25. **Federal or State Exclusion List.** Any service, *drug*, *drug* regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (01G List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists, or other exclusion/sanctioned lists as published by federal or state regulatory agencies. This exclusion does not apply to an *emergency medical condition*.
26. **Foot Care.** Services for routine, palliative, or cosmetic foot care including flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, unless specifically provided herein.
27. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this *Plan*. Services in the case of a *medical emergency* or provided through the Global Core Program are a *covered charge*.
28. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government, except as stated herein. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.
29. **Growth Hormones.** Growth hormones are covered through the prescription drug benefits program.
30. **Habilitation Services.** This exclusion also does not apply to the *medically necessary* treatment of severe mental disorders such as attention deficit disorders and attention deficit hyperactivity disorders (ADD/ADHD), behavioral/learning disabilities, developmental delay, or to the *medically necessary* treatment of pervasive developmental disorder or autism.
31. **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*. This exclusion does not apply to hair loss services attributed to a covered medical condition.
32. **Health Club Memberships.**
33. **Hip Replacement, Knee Replacement, or Spine Surgical Services, Inpatient.** Hip replacement, knee replacement, or spine *surgical procedures* when rendered on an *inpatient* basis are only covered under the *Plan* when be performed at a Blue Distinction+ (BD+) facility. This exclusion would not apply to *plan participants* that meet the outlined exception criteria. If the outlined criteria is met, *plan participants* would receive services at the applicable benefit level. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for details on coverage under the *Plan*.
34. **Hospice Care.** Services for spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling

services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.

35. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
36. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
37. **Hyperhidrosis Treatment.** Medical and *surgical* treatment of excessive sweating (hyperhidrosis).
38. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.
39. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
40. **Infertility Diagnostic Testing or Treatment.** Care, supplies, services, and treatment for *infertility*, including, but not limited to, artificial insemination, in vitro fertilization, or any assisted reproductive technology (ART) procedure.
41. **Long Term Care.**
42. **Maintenance Therapy.**
43. **Maternity**. Charges for services related to surrogate *pregnancy*.
44. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.
45. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
46. **Mobile/Wearable Devices.** Consumer wearable/personal mobile devices such as a smart phone, smart watch, or other personal tracking devices, including any software or applications.
47. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of their peers to have been negligent in their actions, as negligence is defined by the jurisdiction where the activity occurred.
48. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
49. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.
50. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* 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 *illness*.
51. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.
52. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, services for telephone consultations (except MD Live/LiveHealth Online and virtual visits), expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.
53. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, or Rogaine hair preparations, special foods

or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.

54. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
55. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.
56. **Morbid Obesity.** Care or treatment of *morbid obesity*, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*. Specifically excluded are charges for bariatric *surgery*, including, but not limited to, gastric bypass, stapling and intestinal bypass, and lap band *surgery*. Only *medically necessary* surgical charges for *morbid obesity* will be covered, except counseling as outlined herein or as mandated by federal law. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for details on coverage under the *Plan* for bariatric *surgery*.
57. **Obesity.** Care or treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*. *Surgical procedures* are not covered for obesity. This exclusion does not apply to counseling. Refer to the Covered Medical Charges subsection for covered services under the *Plan*.
58. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers' compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.
59. **Orthotics.** Charges in connection with non-custom molded orthotics.
60. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease*, and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.
61. **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, elastic bandages, non-medical grade stockings, non-*prescription drugs* and medicines, first-aid supplies, seat risers, and non-hospital adjustable beds.
62. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family-owned vehicle or a pedestrian.
63. **Prescription Drugs.** Prescription drugs charges covered under the prescription drug benefits, other than those covered in a *physician's* office or *inpatient* admission.
64. **Prior to Effective Date or After Termination Date.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated, unless extension of benefits applies.
65. **Private Contracts.** Services or supplies provided pursuant to a private contract between the *plan participant* and a *physician*, for which reimbursement under the *Medicare* program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
66. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse.
67. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
68. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.

69. **Replacement Devices.** Replacement of orthotics or prosthetics such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the *plan participant's* physical condition to make the original device no longer functional.

70. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital, hospice, skilled nursing facility*, or *residential treatment center*.

    This exclusion includes procedures, equipment, services, supplies, or charges for the following:

    a. domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *plan participant's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included

    b. care provided or 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, supervised living or halfway house, or any similar facility or institution

    c. services or care provided or billed by a school, *custodial care* center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included

71. **Smoking Cessation.** Care and treatment for tobacco cessation (including vaping) programs shall be covered to the extent required under the *Preventive Care* provision. Tobacco cessation care and treatment is otherwise excluded under the medical benefits.

72. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

73. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third party responsibility provisions. Refer to the **Reimbursement and Recovery Provisions** section.

74. **Transplants.** Services and supplies that are *incurred* for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the exclusions stated in the **Blue Distinction Center/Blue Distinction Center+ Program** section. This exclusion would not apply to *plan participants* that meet the outlined exception criteria. If the outlined criteria is met, *plan participants* would receive services at the applicable benefit level.

75. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for ambulance charges defined as a *covered charge*, approved gender services travel, or travel required for an approved organ or tissue transplant. Refer to the **Blue Distinction Center/Blue Distinction Center+ Program** section for details.

76. **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

77. **Vision Care Exclusions.** Expenses for the following:

    a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

    b. diagnosis and treatment of refractive errors, including routine eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular *surgery* when the lens of the eye has been removed such as with a cataract extraction

    c. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids

    d. orthokeratology lenses for reshaping the cornea of the eye to improve vision

78. **War.** Any loss that is due to a declared or undeclared act of war.

79. **Weight Loss Programs.**

80. **Wigs.**

81. **Wilderness.** Wilderness or other outdoor camps and/or programs.

SECTION VI—BLUE DISTINCTION CENTER/BLUE DISTINCTION CENTER+ PROGRAM

A. Transplant Program

The Transplant Program provides access to a *network* of transplant centers that perform many transplants each year and have historically high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

Under the Transplant Program, the *Plan* reimburses you for covered services and supplies arising out of the following human organ and tissue transplants for a *plan participant* recipient:

1. bone marrow
2. cornea
3. double lung
4. heart
5. combination heart/lung
6. intestine
7. kidney
8. kidney/liver
9. kidney/pancreas
10. liver
11. lung
12. pancreas
13. bone marrow/stem cell and similar procedures

When the donor of an organ or tissue is not a *plan participant*, the donor's *hospital*, surgical, and medical expenses will be eligible on the basis of a *claim* made by the *plan participant*. When both the person donating the organ and the person getting the organ are *plan participants* under this *Plan,* each will get benefits under their *Plans*.

The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense *incurred* for *medically necessary* medical services only. The *maximum allowed amount* for services incidental to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six (6) weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to or a direct result of the transplant are not covered.

Medical and surgical treatment or devices related to transplantation that are *experimental*, *investigational*, or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any institutional Review Board for the proposed use; or non-demonstrative through prevailing peer-reviewed medical literature to be efficacious for the treatment of the *disease* state at the time of the request. The *Plan* reserves the right to make final judgment regarding coverage of *experimental*, *investigational*, and unproven procedures and treatments. *Medically necessary* means those transplant-related services which are determined by the *Plan* to be medically appropriate for the diagnosis and clinical status of the *plan participants* and their *dependents*, rendered in an appropriate setting, and of demonstrated medical value. The fact that a *physician* has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a *disease* does not mean that is *medically necessary*.

Transplant-related services are services and supplies up to one (1) year following the transplant, which are related to transplantation when recommended by a *physician*, provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include, but are not limited to, *hospital* charges, *physician* charges, organ acquisition charges, tissue typing donor search charges, and ancillary services.

Transplant Program Benefits

1. access to *network Center of Excellence/Blue Distinction Center*. Travel benefits are only available for access to a *network Center of Excellence/Blue Distinction Center* as outlined in the applicable Schedule of Benefits.
2. reimbursement for travel, lodging, and meal expenses *incurred* during the transplant for *plan participant* and companion(s) who are traveling on the same day(s) to and/or from the site of treatment, for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow-up up to a total maximum of $10,000

Benefits are paid at a per diem (per day) rate of up to $50 per day for the *plan participant* or up to $100 per day for the *plan participant* plus one (1) companion. If the *plan participant* is an enrolled *dependent* and minor child, the transportation expenses of two (2) companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

3. services of a transplant case manager, who will coordinate services and savings

Travel and lodging benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a claim for reimbursement. The listed expenses must be *incurred* within one hundred twenty (120) days after the transplant. Applicable travel expenses will also be covered during the transplant evaluation period. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision.

Covered services are subject to any applicable *deductibles* and *co-payments* set forth in the applicable Schedule of Medical Benefits.

Transplant Requirements

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a *network Center of Excellence/Blue Distinction Center*, and meets all of the following requirements:

1. *Pre-certification* **must** be obtained as outlined in the **Health Care Management Program** section.
2. All transplant services must be rendered at a transplant center facility.

   EXCEPTION: Cornea transplants are not required to be performed in a *Blue Distinction Center/Center of Excellence*.

If these requirements are not met, transplant benefits are not available under the Plan.

Transplant Exclusions

The following transplant-related expenses are not covered by the *Plan*:

1. when the recipient is not an eligible *plan participant*
2. If a *plan participant* under this *Plan* is donating the organ to someone who is not a *plan participant*, benefits are not available under this *Plan*
3. when the organ or tissue is sold rather than donated to the recipient
4. charges that are covered or funded by governmental, foundation, or charitable grants or programs
5. any of the following or similar items associated with travel:
   a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
   b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
   c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals
   d. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
   e. cash advances/lost wages
   f. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*
   g. prepayments or deposits
   h. taxes
   i. travel costs for donor companion/caregiver
   j. return visits for the donor for a treatment of an *illness* found during the evaluation

B. Bariatric Surgery Program

Services and supplies in connection with *medically necessary* bariatric surgery for weight loss are covered under the *Plan*, only for *morbid obesity* and only when performed at a designated *Blue Distinction Center/Center of Excellence* or *Blue Distinction Center+ (BD+)*.

Plan participants must obtain *pre-certification* for all bariatric *surgical procedures*. Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *Blue Distinction Center* or *Blue Distinction Center+ (BD+)* will not be covered.

Covered services are subject to any applicable *deductibles* and *co-payments* set forth in the applicable Schedule of Medical Benefits.

Covered Bariatric Travel Expenses

Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated *Blue Distinction Center/Center of Excellence* or *Blue Distinction Center+ (BD+)* is fifty (50) miles or more from the *plan participant's* place of residence, are covered, provided the expenses are authorized by the *Claims Administrator* in advance. The fifty (50) mile radius around the *Blue Distinction Center/Center of Excellence* or *Blue Distinction Center+ (BD+)* will be determined by the *bariatric Blue Distinction Center/Center of Excellence* or *Blue Distinction Center+ (BD+) coverage area*. The *Plan's* maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the *member* and/or one (1) companion and includes:

1. Transportation for the *plan participant* and/or one (1) companion to and from the *Blue Distinction Center/Center of Excellence* or *Blue Distinction Center+ (BD+)* facility (limited to a three (3) trip maximum for [one (1) pre-operative trip, one (1) surgery trip and one post-operative trip if needed].
2. Flight for the *plan participant* and one (1) companion to and from the *Blue Distinction Center/Center of Excellence* or *Blue Distinction Center+ (BD+)* facility will only be economy / coach seating (preferred seats for *surgery* trip when aisle seat is not available).
3. Check in bag fees will be one (1) bag for the *plan participant*, one (1) bag for companion for each flight.
4. ground transportation (rental) will only be economy / intermediate / standard
5. ground transportation (personal car) – mileage reimbursement is based on current limits set forth in the internal revenue code, not to exceed the maximum amount specified above
6. Other reasonable expenses.

Bariatric Travel Exclusions

Any of the following or similar items associated with travel are excluded under the *Plan*:

1. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
2. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
3. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals
4. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
5. cash advances/lost wages
6. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*
7. prepayments or deposits
8. taxes

C. Hip Replacement, Knee Replacement, or Spine Surgery Program

Inpatient services and supplies provided for *medically necessary* hip, knee replacement or spine surgery when performed by a designated *Blue Distinction Center+ (BD+)*. Benefits for the following services are as follows:

1. total knee replacement
2. revision knee replacement

3. total hip replacement
4. revision hip replacement
5. discectomy
6. decompression (without fusion)
7. primary fusion
8. revision fusion

Covered services are subject to any applicable *deductibles* and *co-payments* set forth in the applicable Schedule of Medical Benefits.

Hip replacement, knee replacement, or spine *surgery* services are subject to ***pre-certification*** to determine *medical necessity*. Benefits are provided for *inpatient* services for *medically necessary* hip replacement, knee replacement, or spine *surgery*.

Hip Replacement, Knee Replacement, or Spine Surgery Travel Exclusions

Any of the following or similar items associated with travel are excluded under the *Plan*:

1. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
2. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
3. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals
4. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
5. cash advances/lost wages
6. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*
7. prepayments or deposits
8. taxes

SECTION VII—HEALTH CARE MANAGEMENT PROGRAM

A. Introduction

The Health Care Management Program consists of several components to assist *plan participants* in staying well: providing optimal management of chronic conditions, provisions of support, and service coordination during times of acute or new onset of a medical condition.

The scope of the Health Care Management Program consists of the following components (each of which will be further discussed in this section):

1. Utilization Review
2. Concurrent Review and Discharge Planning
3. Case Management

B. Utilization Review

The utilization review program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and 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 *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

The *Plan Administrator* has contracted with the *Medical Management Administrator* in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before medical and/or surgical services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered *medical care facility* (based on the admitting diagnosis, of the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment.

What Services Must Be Pre-Certified (Approved Before they are Provided)

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least seven (7) days in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the out-of-pocket limit.

The following services must be *pre-certified* before the services are provided:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long term acute care facility (LTAC), not *custodial care*

c. *skilled nursing facility*/rehabilitation facility

d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

2. *inpatient* and *outpatient surgery* including pain management injections. Pain management injections in excess of $1,000 performed in an office setting also require *pre-certification*. All other office *surgeries* and screening colonoscopies do not require *pre-certification*.
3. bariatric surgical services, such as gastric bypass and other *surgical procedures* for weight loss, including bariatric travel expense, if:
    a. the services are to be performed for the treatment of *morbid obesity*
    b. the *physicians* on the surgical team and the facility in which the *surgical procedure* is to take place are approved for the *surgical procedure* requested
    c. the bariatric *surgical procedure* will be performed at a Blue Distinction (BD) or a Blue Distinction+ BD+) facility
4. *inpatient* hip replacement, knee replacement, or spine surgical services, including hip replacement, knee replacement, or spine *surgery* travel expenses, if:
    a. the services are to be performed for hip replacement, knee replacement, or spine *surgery*
    b. the *physicians* on the surgical team and the facility in which the *surgical procedure* is to take place are approved for the *surgical procedure* requested
    c. the hip replacement, knee replacement, or spine *surgical procedure* will be performed at a Blue Distinction+ (BD+) facility
5. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
6. behavioral treatment for pervasive developmental disorder or autism
7. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
8. dialysis
9. *durable medical equipment* (DME) in excess of $1,000 (purchase/rental price)
10. *gene therapy*
11. genetic/genomic testing (excluding amniocentesis)
12. *home health care services*
13. home infusion therapy or Infusion therapy, if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
14. non-emergent air ambulance
15. orthotics/prosthetics in excess of $1,000 purchase price
16. *outpatient* advanced imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans (excluding services rendered in an emergency room setting)
17. physical therapy, physical medicine, occupational therapy, and chiropractic care in excess of five (5) visits per therapy type, per provider
18. partial hospitalization, intensive outpatient programs, and transcranial magnetic stimulation (TMS)
19. sleep studies/services
20. specialty infusion/injectable medications over $1,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

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

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator* **at least seven (7) days before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

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 *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission. Refer to the Quick Reference Information Chart for contact information.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the *Plan*.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this benefit booklet.

NOTE: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **you may have benefits reduced for any resulting *claims***. Penalty will be applied to the facility charge, if applicable. Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*.

Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (Other Pre-Service Claims subsection) for details on how to *appeal* and the timeframes for appealing a *pre-service claim* decision.

C. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. The *Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* 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 *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

How to File a Concurrent Claim for Benefits under this Plan

Refer to the **Claims and Appeals** section (Concurrent Care Claims subsection) for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

D. Case Management

Case Management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of Case Management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible Case Management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at 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 shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of 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*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under Case Management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by Case Management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All Case Management is a voluntary service. There are no reductions of benefits or penalties assessed 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.

E. Courtesy Reviews

The *Medical Management Administrator* may perform *courtesy reviews*. *Courtesy reviews* are a pre-service assessment of *medical necessity* only and are not a guarantee of benefits. *Courtesy reviews* will be made as soon as possible after the request has been submitted, but no later than thirty (30) days. Completion of a *courtesy review* is not a requirement of the *Plan* and should not be a cause for delay in treatment of *medically necessary* care. Contact the *Medical Management Administrator* for any questions. Refer to the **Claims and Appeals** section for timeframes and other information regarding filing *claims*.

SECTION VIII—CLAIMS AND APPEALS

A. Introduction

This section contains the *claims* and *appeals* procedures and requirements for the Self-Insured Schools of California (SISC).

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines. *Non-network claims* must be submitted within one hundred eighty (180) days after the date of service. In certain cases, state or federal law may allow additional time to file a *claim*, if you could not reasonably file within the one hundred eighty (180) day period.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

For purposes of these *appeal* provisions, "claim for benefits" means a request for benefits under the *Plan*. The term includes both pre-service and post-service claims.

1. A *pre-service claim* is a *claim* for benefits under the *Plan* for which you have not received the benefit or for which you may need to obtain approval in advance.
2. A *post-service claim* is any other claim for benefits under the *Plan* for which you have received the service. If your *claim* is denied:
    a. you will be provided with a written notice of the denial
    b. you are entitled to a full and fair review of the denial

The procedure the *Claims Administrator* will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

B. Notice of Adverse Benefit Determination

If your *claim* is denied, the *Claims Administrator's* notice of the adverse benefit determination (denial) will include:

1. information sufficient to identify the claim involved
2. the specific reason(s) for the denial
3. a reference to the specific *plan* provision(s) on which the *Claims Administrator's* determination is based
4. a description of any additional material or information needed to perfect your *claim*
5. an explanation of why the additional material or information is needed
6. a description of the *Plan's* review procedures and the time limits that apply to them, if you *appeal* and the *claim* denial is upheld
7. information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the *claim* determination and about your right to request a copy of it free of charge, along with a discussion of the *claims* denial decision
8. information about the scientific or clinical judgment for any determination based on *medical necessity* or *experimental* treatment, or about your right to request this explanation free of charge, along with a discussion of the *claims* denial decision
9. information regarding your potential right to an external appeal pursuant to federal law. For *claims* involving urgent/concurrent care:
    a. the *Claims Administrator's* notice will also include a description of the applicable urgent/concurrent review process
    b. the *Claims Administrator* may notify you or your authorized representative within seventy-two (72) hours orally and then furnish a written notification.

C. Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your *appeal* within one hundred eighty (180) *calendar days* after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your *claim*. The *Claims Administrator's* review of your *claim* will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The *Claims Administrator* shall offer a single mandatory level of *appeal* which may be a panel review, independent review, or other process consistent with the entity reviewing the *appeal*. The time frame allowed for the *Claims Administrator to* complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

D. Pre-Service Claims

For *pre-service claims* involving urgent/concurrent care, you may obtain an expedited *appeal*. You or your *authorized representative* may request it orally or in writing. All necessary information, including the *Claims Administrator's* decision, can be sent between the *Claims Administrator* and you by telephone, facsimile, or other similar method. To file an *appeal* for a *claim* involving urgent/concurrent care, you or your *authorized representative* must contact the *Claims Administrator* at the phone number listed on your ID card and provide at least the following information:

1. the identity of the claimant
2. the date (s) of the medical service
3. the specific medical condition or symptom
4. the provider's name
5. the service or supply for which approval of benefits was sought
6. any reasons why the appeal should be processed on a more expedited basis

All other requests for appeals should be submitted in writing by the *plan participant* or the *plan participant's authorized representative*, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your *authorized representative* must submit a request for review to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

E. You Must Include Your Member Identification Number When Submitting An Appeal

Upon request, the *Claims Administrator* will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your *claim*. "Relevant" means that the document, record, or other information:

1. was relied on in making the benefit determination
2. was submitted, considered, or produced in the course of making the benefit determination
3. demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *Plan,* applied consistently for similarly situated claimants
4. is a statement of the *Plan's* policy or guidance about the treatment or benefit relative to your diagnosis

The *Claims Administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your *claim*. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the *Claims Administrator* will provide you, free of charge, with the rationale.

F. How Your Appeal will be Decided

When the *Claims Administrator* considers your *appeal*, the *Claims Administrator* will not rely upon the initial benefit determination to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is *experimental/investigational*, or not *medically necessary,* the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

G. Notification of the Outcome of the Appeal

If You Appeal A Claim Involving Urgent/Concurrent Care

The *Claims Administrator* will notify you of the outcome of the *appeal* as soon as possible, but not later than seventy-two (72) hours after receipt of your request for *appeal*.

If You Appeal Any Other Pre-Service Claim

The *Claims Administrator* will notify you of the outcome of the *appeal* within thirty (30) days after receipt of your request for *appeal*.

If You Appeal A Post-Service Claim

The *Claims Administrator* will notify you of the outcome of the *appeal* within sixty (60) days after receipt of your request for *appeal*.

H. Appeal Denial

If your *appeal* is denied, that denial will be considered an adverse benefit determination. The notification from the *Claims Administrator* will include all of the information set forth in the above subsection entitled Notice of Adverse Benefit Determination subsection."

I. External Review

If the outcome of the mandatory first level *appeal* is adverse to you and it was based on medical judgment, you may be eligible for an independent *external review* pursuant to federal law.

You must submit your request for *external review* to the *Claims Administrator* within four (4) months of the notice of your final internal adverse determination.

A request for an *external review* must be in writing unless the *Claims Administrator* determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited *external review* without filing an internal appeal or while simultaneously pursuing an expedited appeal through the *Claims Administrators* internal appeal process. You or your *authorized representative* may request it orally or in writing. All necessary information, including the *claims administrator's* decision, can be sent between the *Claims Administrator* and you by telephone, facsimile, or other similar method. To proceed with an expedited *external review*, you or your *authorized representative* must contact the *Claims Administrator* at the phone number listed on your ID card and provide at least the following information:

1. the identity of the claimant;
2. the date (s) of the medical service;
3. the specific medical condition or symptom;
4. the provider's name;
5. the service or supply for which approval of benefits was sought; and
6. any reasons why the appeal should be processed on a more expedited basis.

All other requests for *external review* should be submitted in writing unless the *Claims Administrator* determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your *authorized representative* to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

The federal *external review* process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a *claimant* or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The federal *external review* process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible a*dverse benefit determination* (including a final Internal *adverse benefit determination*) by a *Plan* or issuer that involves medical judgment (including, but not limited to, those based on the *Plan's* or issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is e*xperimental/investigational*; its determination whether a *claimant* or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An *adverse benefit determination* that involves consideration of whether the *Plan* is complying with the surprise billing and cost sharing protections set forth in the No Surprises Act
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time)

J. You Must Include Your Member Identification Number When Submitting An Appeal

This is not an additional step that you must take in order to fulfill your *appeal* procedure obligations described above. Your decision to seek *external review* will not affect your rights to any other benefits under this health care *Plan*. There is no charge for you to initiate an independent *external review*. The *external review* decision is final and binding on all parties except for any relief available through applicable state laws.

K. Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the *Plan's* final decision on the claim or other request for benefits. If the *Plan* decides an appeal is untimely, the *Plan's* latest decision on the merits of the underlying *claim* or benefit request is the final decision date. You must exhaust the *Plan's* internal *appeals* procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the *Plan*.

If you choose to retain an attorney, expert, consultant or any other individual to assist in presentation of a claim, it must be at your own expense. Neither the Plan nor the Claims Administrator will reimburse you for the costs associated with such a retention or for any other expenses you may incur in connection with such a retention.

The *Claims Administrator* reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

L. Designation of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on behalf of the *plan participant* with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

M. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

N. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

O. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant*, and in the absence of written evidence to this *Plan* of the qualification of a guardian for their estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

P. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which they are a *plan participant* in the *Plan*, or following their termination as a *plan participant*, in any manner, have any right to assign their right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan*, or to any other causes of action which they may have against the *Plan* or its fiduciaries.

A provider which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Q. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such, this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement And Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of their covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

If the *Plan* seeks to recoup funds from a provider due to a *claim* being made in error, a *claim* being fraudulent on the part of the provider, and/or a *claim* that is the result of the provider's misstatement, said provider shall, as part of its *assignment of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount.

SECTION IX—BINDING ARBITRATION

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

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

The *plan participant* and the *Plan Administrator* agree to be bound by this binding arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

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

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

The arbitration is begun by the *member* making written demand on the *Plan Administrator*. Any demand for arbitration must be made within one (1) year from the issuance by the *Claims Administrator* of its decision following *appeal*. In cases where the amount in controversy is within the jurisdiction of small claims court, suit must be filed within one (1) year from the issuance by the *Claims Administrator* of its decision following *appeal*. Failure to demand arbitration or file in small claims court within one (1) year of the issuance by the *Claims Administrator* of its decision following appeal shall result in the forfeiture of any right to arbitration or to take any other legal action. Any written demand should be sent to the *Plan Administrator* at the address shown below:

SISC

P.O. Box 1847

Bakersfield, CA 93303-1847

The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *plan participant* and the *Plan Administrator,* or by order of the court, if the *plan participant* and the *Plan Administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the *plan participant* and the *Plan Administrator*.

If you choose to retain an attorney, expert, consultant, or any other individual to assist in presentation of a claim, it must be at your own expense. Neither the Plan nor the Claims Administrator will reimburse you for the costs associated with such a retention or for any other expenses you may incur in connection with such a retention.

SECTION X—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan, or the couple's covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Standard Coordination of Benefits (COB)

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 charges*.

Example: Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

Primary Plan	$800
Secondary Plan	$200
Patient Responsibility	$0
Total Amount Paid	$1,000

B. Excess Insurance

If at the time of *injury*, *illness*, *disease*, or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage.

The *Plan's* benefits will be excess to, whenever possible:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

C. Allowable Charge

For a charge to be allowable it must be within the *Plan's maximum amount* and at least part of it must be covered under this *Plan*.

In the case of HMO (health maintenance organization) or other *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 *plan participant* 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 *plan participant* 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*.

D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order 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 charges*. When there is a conflict in the rules, this *Plan* will never pay more than 50% of *allowable charges* when paying secondary. Benefits will be coordinated as referenced in the Claims Determination Period subsection.

When medical payments are available under automobile insurance, this *Plan* will pay excess benefits only, without reimbursement for automobile plan *deductibles*. This *Plan* will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when either:

1. the *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined
2. the rules in the subsection entitled Benefit Plan Payment Order would require this *Plan* to determine its benefits before the *other plan*

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

2. Plans that do not have a coordination provision, or one like this, will pay first. Plans with such a provision will be considered after those without one.
3. 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, or subscriber) are determined before those of the plan which covers the person as a *dependent*.
    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 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.) immediately 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 (1) 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. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of *allowable charges* when paying secondary.

g. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

4. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the *Medicare* publication Your Guide to Who Pays First at **https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, 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 any 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 Centers for Medicare & Medicaid Services (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.

5. 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.

6. When an adult *dependent* is covered by their spouse's plan and is also covered by a parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

7. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

8. The *Plan* will pay primary to Tricare and a state *Children's Health Insurance Plan* to the extent required by federal law.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.

2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

3. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this *Plan* pays second, unless applicable law dictates otherwise.

H. Claims Determination Period

Benefits will be coordinated on a *calendar year* basis. This is called the claims determination period.

I. Right to Receive or Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or *notice* to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. 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*.

K. Right of Recovery

In accordance with the **Claims and Appeals** section, Recovery of Payments subsection, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or their *dependents*. Please see the Recovery of Payments subsection for more details.

L. Exception to Medicaid

The *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

SECTION XI—MEDICARE

A. Application to Active Employees and Their Spouses

An active *employee* and their spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as the secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Parts A & B) whether or not the *plan participant* has enrolled for the full coverage. If the provider accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

SECTION XII—SUBROGATION AND REIMBURSEMENT

These provisions apply when the *plan* pays benefits as a result of *injuries* or *illnesses* you sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a recovery, it shall be subject to these provisions.

A. Subrogation

The *Plan* has the right to recover payments it makes on your behalf from any party responsible for compensating you for your *illnesses* or *injuries*. The following apply:

1. The *Plan* has first priority from any recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, *illnesses,* and/or *injuries*.
2. You and your legal representative must do whatever is necessary to enable the *Plan* to exercise the *Plan's* rights and do nothing to prejudice those rights.
3. In the event that you or your legal representative fail to do whatever is necessary to enable the *Plan* to exercise its subrogation rights, the *Plan* shall be entitled to deduct the amount the *Plan* paid from any future benefits under the *Plan*.
4. The *Plan* has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *Plan*.
5. To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the *Plan's* subrogation *claim* and any *claim* held by you, the *Plan's* subrogation *claim* shall be first satisfied before any part of a recovery is applied to your *claim*, your attorney fees, other expenses, or costs.
6. The *Plan* is not responsible for any attorney fees, attorney liens, other expenses, or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *Plan*.

B. Reimbursement

If you obtain a recovery and the *Plan* has not been repaid for the benefits the *Plan* paid on your behalf, the *Plan* shall have a right to be repaid from the recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

1. You must reimburse the *Plan* from any recovery to the extent of benefits the *plan* paid on your behalf regardless of whether the payments you receive make you whole for your losses, *illnesses* and/or *injuries*.
2. Notwithstanding any allocation or designation of your recovery (e.g., pain and suffering) made in a settlement agreement or court order, the *Plan* shall have a right of full recovery, in first priority, against any recovery. Further, the *Plan's* rights will not be reduced due to your negligence.
3. You and your legal representative must hold in trust for the *plan* the proceeds of the gross recovery *(i.e.,* the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the *Plan* immediately upon your receipt of the recovery. You and your legal representative acknowledge that the portion of the recovery to which the *plan's* equitable lien applies is a *Plan* asset
4. Any recovery you obtain must not be dissipated or disbursed until such time as the *Plan* has been repaid in accordance with these provisions.
5. You must reimburse the *Plan,* in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *Plan*.
6. If you fail to repay the *Plan,* the *Plan* shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the *Plan* has paid or the amount of your recovery whichever is less, from any future benefit under the *Plan* if:
    a. the amount the *Plan* paid on your behalf is not repaid or otherwise recovered by the *Plan*

b. you fail to cooperate

7. In the event that you fail to disclose the amount of your settlement to the *Plan,* the *Plan* shall be entitled to deduct the amount of the *Plan's* lien from any future benefit under the *Plan*.
8. The *Plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *plan* has paid or the amount of your recovery, whichever is less, directly from the providers to whom the *Plan* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the *Plan* will not have any obligation to pay the provider or reimburse you.
9. The *Plan* is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement, or underlying *claim* for damages or fully compensate you or make you whole.

C. Your Duties

1. You must promptly notify the *Plan* of how, when and where an accident or incident resulting in personal *injury* or *illness* to you occurred and all information regarding the parties involved and any other information requested by the *Plan*.
2. You must cooperate with the *Plan* in the investigation, settlement, and protection of the *Plan's* rights. In the event that you or your legal representative fail to do whatever is necessary to enable the *Plan* to exercise its subrogation or reimbursement rights, the *Plan* shall be entitled to deduct the amount the *Plan* paid from any future benefits under the *Plan*.
3. You must not do anything to prejudice the *Plan's* rights
4. You must send the *Plan* copies of all police reports, notices, or other papers received in connection with the accident or incident resulting in personal *injury* or *illness* to you.
5. You must promptly notify the *Plan* if you retain an attorney or if a lawsuit is filed on your behalf
6. You must immediately notify the *Plan* if a trial is commenced, if a settlement occurs, or if potentially dispositive motions are filed in a case.

The *Plan Administrator* has sole discretion to interpret the terms of the **Subrogation and Reimbursement** section of this *Plan* in its entirety and reserves the right to make changes as it deems necessary.

If the *plan participant* is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any recovery because of injuries sustained by the covered person, that recovery shall be subject to this provision.

The *Plan* is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The *Plan* shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The *Plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

SECTION XIII—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), *as Amended*, certain *employees* and their families covered under the Self-Insured Schools of California (SISC) (*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.

Refer to the Quick Reference Information Chart for the COBRA Administrator's contact information for complete instructions on COBRA, as well as election forms and other information, will be provided by the *Plan Administrator* or its designee 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 thirty (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*.

A. 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).

COBRA continuation coverage does not run concurrent with the coverage under the terms of the *Plan*.

B. 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 who otherwise qualifies as a qualified beneficiary 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 Child Support Order*. If, however, an individual who otherwise qualifies as a qualified beneficiary 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.
3. A covered *employee* who retired on or before the date of substantial elimination of *Plan* coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse, or *dependent* child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or *dependent* child was a beneficiary under the *Plan*.

The term 'covered *employee*' includes any individual who is provided coverage under the *Plan* due to their performance of services for the *employer* sponsoring the *Plan*, 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's* **Eligibility, Effective Date, and Termination Provisions** section.

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 and their children are not qualified beneficiaries and do not have an independent right to elect COBRA continuation coverage. However, if an *employee* who is a qualified beneficiary elects COBRA continuation coverage, they may also elect to continue coverage for their domestic partner and children or qualified *dependents* if they are covered under the *Plan* on the day before the qualifying event.

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.

C. Qualifying Event

The following are considered to by qualifying events if they would cause the *plan participant* to 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 twelve (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*, the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one (1) of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (FMLA) 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*.

D. Notice of Unavailability of Continuation Coverage

The *Plan* may sometimes deny a request for COBRA coverage, including an extension of coverage, when the *Plan Administrator* determines the *plan participant* is not entitled to receive it.

When a *Plan Administrator* makes the decision to deny a request for COBRA coverage from a *plan participant*, the *Plan* must give the *plan participant* a *notice* of unavailability of COBRA coverage. The *notice* must be provided within fourteen (14) days after the request is received relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration, and the *notice* must explain the reason for denying the request.

E. Factors to Consider in Electing COBRA Continuation Coverage

When considering options for health coverage, qualified beneficiaries should consider:

1. **Premiums.** This *Plan* can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. Qualified beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's *employer*) within thirty (30) days after *Plan* coverage ends due to one of the qualifying events listed above.
2. **Provider Networks.** If a qualified beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a *network* in considering options for health coverage.
3. **Drug Formularies.** For qualified beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
4. **Severance Payments.** If COBRA rights arise because the *employee* has lost their job and there is a severance package available from the *employer*, the former *employer* may have offered to pay some or all of the *employee's* COBRA payments for a period of time. This can affect the timing of coverage available in the marketplace. In this scenario, the *employee* may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
5. **Service Areas.** If benefits under the *Plan* are limited to specific service or coverage areas, benefits may not be available to a qualified beneficiary who moves out of the area.
6. **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, the *Plan* requires *participants* to pay *co-payments*, *deductibles*, *co-insurance*, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher *deductible* and higher *co-payments*.

Other Coverage Options

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**.

F. 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.

G. The Election Period

The election period is the timeframe within which the qualified beneficiary must elect COBRA continuation coverage under the *Plan*. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event and ends sixty (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 their right to elect COBRA continuation coverage. If coverage is not elected within the sixty (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 Preferences Extension Act of 2015, and the *employee* and their 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 sixty (60) days or less and only during the six (6) months immediately after their group health plan coverage ended. Any person who qualifies or thinks that they and/or their 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.

H. Responsibility 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 thirty (30) days following the date coverage ends when the qualifying event is any of the following:

1. the end of employment or reduction of hours of employment
2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to the *employer*
4. enrollment of the *employee* in any part of *Medicare*

IMPORTANT:

For the other qualifying events (divorce 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 sixty (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 sixty (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, department, or firm listed below, at the following address:

Self-Insured Schools of California
P.O. Box 1847
Bakersfield, CA 93303-1847
1-661-636-4410

If mailed, your *notice* must be postmarked no later than the last day of the required *notice* period. Any *notice* you provide must state all of the following:

1. the name of the plan or plans under which you lost or are losing coverage
2. the name and address of the *employee* covered under the *Plan*
3. the name(s) and address(es) of the qualified beneficiary(ies)
4. 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 you or your spouse or *dependent* children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

I. Waiver Before the End of the Election Period

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.

J. 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, they become entitled to *Medicare* or become covered under other group health plan coverage.

K. When a Qualified Beneficiary's COBRA Continuation Coverage Can 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. twenty-nine (29) months after the date of the qualifying event
    b. the first day of the month that is more than thirty (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
    c. 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.

When the *Plan* terminates COBRA coverage early for any of the reasons listed above, the *Plan Administrator* must give the qualified beneficiary a *notice* of early termination. The *notice* must be given as soon as practicable after the decision is made, and it must describe all of the following:

1. the date of termination of COBRA coverage
2. the reason for termination
3. any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy

L. 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 either:
    a. eighteen (18) months after the qualifying event if there is not a disability extension
    b. twenty-nine (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. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program
    b. eighteen (18) months [or twenty-nine (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 thirty-six (36) months after the qualifying event.

M. Circumstances in Which the Maximum Coverage Period Can Be Expanded

If a qualifying event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second qualifying event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (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 thirty-six (36) months after the date of the first qualifying event. The *Plan Administrator* must be *notified* of the second qualifying event within sixty (60) days of the second qualifying event. This *notice* must be sent to the *Plan Sponsor* in accordance with the procedures above.

N. How a Qualified Beneficiary Becomes 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 at any time during the first sixty (60) days 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 sixty (60) days of the date of the determination and before the end of the original eighteen (18) month maximum coverage. Said *notice* shall be provided to the *Plan Administrator*, in writing, and should be sent to the *Plan Sponsor* in accordance with the procedures above.

O. 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.

The *Plan* must allow payment for COBRA continuation coverage to be made in monthly installments. The *Plan* is also permitted to allow for payment at other intervals.

P. Timely Payment for COBRA Continuation Coverage

Timely payment means a payment made no later than thirty (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 forty-five (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 thirty (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.

Q. Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage

If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the *Plan* will, during the one hundred eighty (180) day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the *Plan*.

R. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the *Plan Sponsor*. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

S. 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*.

T. If You Wish to Appeal

In an effort to provide all qualified beneficiaries with a fair and thorough review process for COBRA related *claims*, all determinations regarding COBRA eligibility and coverage will be made in accordance with the **Continuation Coverage Rights Under COBRA** section of this governing benefit booklet Accordingly, if a qualified beneficiary wishes to *appeal* a COBRA eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. A qualified beneficiary who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under COBRA.

SECTION XIV—STATE LAW RIGHTS

A. Enforce Your Rights

Plan participants may be entitled to certain rights and protections pursuant to California's insurance regulations and/or insurance laws.

To further understand *participant* rights under state, local, or tribal law, please visit:

https://www.dmhc.ca.gov/healthcareincalifornia/typesofplans/keepyourhealthcoverage(cobra).aspx

B. Assistance with Your Questions

If the *plan participant* has any questions about the *Plan*, they should contact the *Plan Administrator*. If the *plan participant* has any questions about this statement or their rights under the law, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, that *plan participant* should contact either the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

SECTION XV—FEDERAL NOTICES

A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health insurance program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or CHIP coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

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.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

Regardless of any limitations on benefits for *mental disorders/substance use disorder* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section
2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., your *physician*, nurse midwife or *physician* assistant), discharges the mother or newborn after consultation with the mother.

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to

satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    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 must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (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 re-employment 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* as outlined in the Quick Reference Information Chart. 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.

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

SECTION XVI—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the *Plan Sponsor's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (PHI) (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *Plan Sponsor's* workforce unless each of the conditions set out in this **Compliance with HIPAA Privacy Standards** section is met. 'Protected Health Information' shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present, or future physical or *mental health* or condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to business associates and members of the *Plan Sponsor's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms 'payment' and 'health care operations' shall have the same definitions as set out in the *Privacy Standards*, but the term 'payment' generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. 'Health care operations' generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training, or accreditation of health care providers; underwriting, premium rating, and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *Plan Sponsor's* workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this **Compliance with HIPAA Privacy Standards** section, members of the *Plan Sponsor's* workforce shall refer to all *employees* and other persons under the control of the *Plan Sponsor*.
    a. **Updates Required.** The *Plan Sponsor* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. **Use and Disclosure Restricted.** An authorized member of the *Plan Sponsor's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the *Plan*.
    c. **Resolution of Issues of Noncompliance.** In the event that any member of the *Plan Sponsor's* workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised
        ii. applying appropriate sanctions against the person(s) causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment
        iii. mitigating any harm caused by the breach, to the extent practicable
        iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages
        v. providing *notification* in accordance with HIPAA requirements
4. **Certification of Employer.** The *Plan Sponsor* must provide certification to the *Plan* that it agrees to all of the following:

a. not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law

b. ensure that any agent or subcontractor to whom it provides Protected Health Information received from the *Plan* agrees to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such information

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *Plan Sponsor*

d. report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law

e. make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*

f. make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*

g. make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*

h. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*

i. if feasible, return or destroy all Protected Health Information received from the *Plan* that the *Plan Sponsor* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible

j. ensure the adequate separation between the *Plan* and member of the *Plan Sponsor's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*

5. The following members of Self-Insured Schools of California's workforce are designated as authorized to receive Protected Health Information from Self-Insured Schools of California (SISC) (*Plan*) in order to perform their duties with respect to the *Plan*:

   a. the *Plan's* Privacy Officer

   b. SISC Health Benefits staff involved in the administration of this *Plan*

   c. Business Associates under contract to the *Plan* including but not limited to the PPO medical, dental and vision plan claims administrator, preferred provider organization (PPO) networks, retail prescription drug benefit plan administrator, the Wellness program, the telemedicine program, the Medicare supplement administrator, the COBRA administrator, Health Flexible Spending Account (FSA) administrator, the *Plan's* attorneys, accountants, consultants, and actuaries.

B. Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *Plan Sponsor* agrees to the following:

1. The *Plan Sponsor* agrees to implement *reasonable* and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the *Plan Sponsor* creates, maintains, or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The *Plan Sponsor* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement *reasonable* and appropriate security measures to protect the Electronic Protected Health Information.

3. The *Plan Sponsor* shall ensure that *reasonable* and appropriate security measures are implemented to comply with the conditions and requirements set forth in **Compliance with HIPAA Privacy Standards**, provisions Authorized Employees and Certification of Employers described above.

SECTION XVII—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Active Employment

Performance by the *employee* of all the regular duties of their occupation at an established business location of the participating *employer*, or at another location to which they may be required to travel to perform the duties of their employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if they have effectively terminated employment.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, cellular adoptive immunotherapy, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a *plan participant*.

Ambulatory Surgical Center

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 (R.N.s), and does not provide for overnight stays.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors.

The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

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

Assignment of Benefits

An arrangement by which a patient may request that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your Protected Health Information (PHI) and act on all matters related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. Where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Birthing Center

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 the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. 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

Blue Distinction Center/Blue Distinction Center+

Blue Distinction Center (BDC) Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

See also *Center of Excellence*.

Brand Name

A trade name medication.

Calendar Year/Benefit Year

January 1st through December 31st of the same year. All *deductibles* and benefit maximums accumulate during the calendar year.

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Center of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The *Plan Administrator* shall determine what *network* Centers of Excellence are to be used.

Any *plan participant* in need of an organ transplant may contact the *Third Party Administrator* as outlined in the Quick Reference Information Chart to initiate the *pre-certification* process resulting in a referral to a Center of Excellence. The *Third Party Administrator* acts as the primary liaison with the Center of Excellence, patient, and attending *physician* for all transplant admissions taking place at a Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to *plan participant(s)* and updated as requested.

Certified IDR Entity

An entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant.'

Claims Administrator

See *Third Party Administrator*.

Clean Claim

A *claim* that can be processed in accordance with the terms of this benefit booklet without obtaining additional information from the service provider or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays *timely payment*. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for usual and/or customariness and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the participant has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Care Claim

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time

services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the pre-certification list nor an exclusion of the *Plan*.

Covered Charges

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply, meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable Schedule of Medical Benefits section and as determined elsewhere in this document.

Custodial Care

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. The following are examples of custodial care:

1. help in walking and getting out of bed
2. assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

For information regarding eligibility for dependents, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions**.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the

applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

Emergency

A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, and hemorrhage. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an emergency did exist. The *Plan* may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

Emergency Medical Condition

A medical condition of recent onset and severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.

Emergency Services

Services furnished with respect to an *emergency medical condition*, as follows:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a *hospital* or of an *independent freestanding emergency department*, as applicable, including ancillary services routinely available to the emergency department to evaluate such *emergency medical condition*; and
2. Within the capabilities of the staff and facilities available at the *hospital* or the *independent freestanding emergency department*, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an *independent freestanding emergency department*, to stabilize the patient (regardless of the department of the *hospital* in which such further examination or treatment is furnished).

When furnished with respect to an *emergency medical condition*, emergency services also include an item or service provided by a *non-participating provider* or non-*participating health care facility* (regardless of the department of the *hospital* in which items or services are furnished) after the *plan participant* is stabilized and as part of *outpatient* observation or an *inpatient* or *outpatient* stay with respect to the visit in which the emergency services are furnished, until such time as the provider determines that the *plan participant* is able to travel using non-medical transportation or non-emergency medical transportation, and the *plan participant* is in a condition to, and in fact does, give informed consent to the provider to be treated as a *non-network* provider.

Employee

A person who is active on the regular payroll of the *employer*, has begun to perform the duties of their job with the *employer*, and is regularly scheduled to work for the *employer* on a full or part-time basis in an employee/*employer* relationship.

Employer

See also *Participating Employer*.

Enrollment Date

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

Experimental/Investigational

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, any of which comprise a definition of experimental/investigational:

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

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigative, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination*, under applicable state or federal external review procedures.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been

exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal *adverse benefit determination* that triggers the right to *external review*.

FMLA Leave

A *leave of absence* which the *employer* is required to extend to an *employee* under the provisions of the FMLA.

Formulary

A list of prescription medications compiled by the third-party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

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.

Genetic Information

Information about the genetic tests of an individual or their family members and information about the manifestations of *disease* or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested *disease*, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

Habilitative Services/Habilitation Services

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an *HSA* in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an *HSA* program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount, set forth by federal law, which is higher than a traditional health plan *deductible*.

Home Health Care Agency

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 thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* 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 (R.N.); 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 supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, and home health care, and counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

A bodily disorder, congenital defects, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department

A health care facility that is geographically separate and distinct, and licensed separately, from a *hospital* under applicable state law, and which provides any *emergency services*.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Infertility

Incapable of producing offspring.

Injury

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

In-Network

See *Network*.

Inpatient

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

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community *mental health* center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Behavioral Intervention

Means any form of *applied behavioral analysis* that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Intensive Care Unit

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 lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

Legal Guardian

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.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted livings.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical condition, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *Illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. *network non-participating provider* rate
3. 200% of the *Medicare* rate
4. the negotiated rate established in a contractual arrangement with a provider
5. the *usual and customary* and/or *reasonable* amount
6. the actual billed charges for the covered services

For *claims* subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within Section III - Medical Network Information) if no negotiated rate exists, the maximum allowable charge will be the *qualifying payment amount* or an amount deemed payable by a *certified IDR entity* or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the *Plan Administrator* will exercise its discretion to determine the maximum allowable charge based on any of the following: *Medicare* reimbursement rates, *Medicare* cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one (1) treatment option is available, and one (1) option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the *maximum allowable charge*. The *maximum allowable charge* will be limited to an amount which, in the *Plan Administrator*'s discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their

consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The *Plan* has the discretionary authority to decide if a *charge* is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical 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 services; is not conducted for research purposes; 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 *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

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

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. 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.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *in-patient facility*, of an individual who is either posing a danger to themselves or others, or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage offered in connection with such a plan).

Morbid Obesity

Severity of obesity judged appropriate for procedure, as indicated by one (1) or more of the following:

1. adult patient has BMI of forty (40) or greater
2. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of 40 (or 140% of the 95th percentile in age and sex matched growth chart) or greater
3. adult patient has BMI of thirty-five (35) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis, difficult to control hypertension)
4. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of thirty-five (or 120% of the 95th percentile in an age and sex matched growth chart) or greater and a clinically serious condition related to obesity [e.g. type 2 diabetes, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, Blount disease (tibia vara), slipped capital femoral epiphysis]
5. adult patient has BMI of thirty (30) or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a non-*participating provider* within the designated *network* area.

Non-Participating Provider

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

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.

Participating Employer

The agreement between Self-Insured Schools of California and the participating employer providing for the participation of specified *employees* in this *Plan*.

Participating Health Care Facility

A *hospital* or hospital *outpatient* department, critical access *hospital*, *ambulatory surgical center*, or other provider as required by law, which has a direct or indirect contractual relationship with the *Plan* with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Participation Agreement

The agreement between Self-Insured Schools of California and the *participating employer* providing for the participation of specified *employees* in this *Plan*.

Participating Provider

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pervasive Developmental Disorder or Autism

Means one (1) or more of disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), 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 their license.

Plan

Self-Insured Schools of California (SISC), which is a benefits plan for certain *employees* of Self-Insured Schools of California and is described in this document. Self-Insured Schools of California (SISC) is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Self-Insured Schools of California, which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

Self-Insured Schools of California

Plan Year

The twelve (12) month period beginning on the day following the end of the first plan year which is a short plan year.

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.

2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

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 an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the Health Care Management Program).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, internists/internal medicine, OBGYNs and their nurse practitioners, obstetricians, and pediatricians.

Charges from nurse practitioners and physician's assistants will be considered at the level of the provider they bill under.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Autism Service Paraprofessional

Is an unlicensed and uncertified individual who meets all of the following requirements:

1. is employed and supervised by a qualified autism service provider
2. provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider
3. meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services
4. has adequate education, training, and experience, as certified by a qualified autism service provider

Qualified Autism Service Professional

Is a provider who meets all of the following requirements:

1. provides behavioral health treatment
2. is employed and supervised by a qualified autism service provider
3. provides treatment according to a treatment plan developed and approved by the qualified autism service provider
4. is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation or who meets equivalent criteria in the state in which he or she practices if not providing services in California
5. has training and experience in providing services for pervasive developmental disorder or autism pursuant to applicable state law

Qualified Autism Service Provider

Is either of the following:

1. A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified
2. A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

Qualifying Payment Amount

The median of the contracted rates recognized by the *Plan* for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a qualifying payment amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Reasonable

In the *Plan Administrator's* discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

Recognized Amount

Except for n*on-network* air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for *non-network* air ambulance services generally, the *recognized amount* shall mean the lesser of a provider's billed charge or the *qualifying payment amount*.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) 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 twenty-four (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, *custodial care*, or educational care.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by The Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

    This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

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.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of their participating *employer*.

SECTION XVIII—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

Self-Insured Schools of California, hereby adopts the provisions of this Self-Insured Schools of California (SISC), and its duly authorized officer has executed this benefit booklet effective the first day of October 2023.

By: _____ Date: 1-23-24

Title: Director of Health Benefits

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-877-379-4844.

P.O. Box 7186
Boise ID 83707