

MCSIG Benefits: Great Plans, Great Value!

Employee Benefit Booklet
Exclusive Provider Option
(EPO Plan)



Dear Plan member:

This Benefit booklet provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

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

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

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

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to MCSIG, 76 Stephanie Dr., Salinas, CA 93901 marked to the attention of the Customer Service Department). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

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



Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY



Funding of Claims provided by:

Monterey County Schools Insurance Group (MCSIG)

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	1
GENERAL INFORMATION	8
DEFINITIONS	9
HOW TO USE YOUR PLAN	25
MEDICAL BENEFITS	25
INTRODUCTION	25
HOW TO USE THE PRUDENT BUYER PROVIDER NETWORK	25
WHY YOU SHOULD USE PARTICIPATING PROVIDERS:	25
WHAT SERVICES REQUIRE PRIOR APPROVAL?	26
CAN I GO DIRECTLY TO A SPECIALIST?	26
ARE THERE PARTICIPATING PROVIDER BENEFITS WHEN OBTAINING CARE OUT-OF-STATE?	27
WHAT IF I REQUIRE MEDICAL ATTENTION WHEN MY DOCTOR'S OFFICE IS CLOSED?	28
WHERE DO I GO FOR LABORATORY SERVICES?	28
WHERE TO CALL WHEN YOU HAVE A QUESTION OR PROBLEM:	28
HOW TO FILE AN APPEAL OF ELIGIBILITY, BENEFITS OR TREATMENT	29
ADDITIONAL BENEFITS	30
CHIROPRACTIC CARE	30
PRESCRIPTION DRUG PROGRAM	31
LIFE INSURANCE	31
VISION CARE	31
DENTAL CARE	31
MCSIG MESSAGE	32
DESCRIPTION OF BENEFITS	33
MEDICAL BENEFITS	33
HOW COVERED EXPENSE IS DETERMINED	33

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND	
MEDICAL BENEFIT MAXIMUMS	34
DEDUCTIBLES	34
CO-PAYMENTS	35
OUT-OF-POCKET AMOUNTS	36
MEDICAL BENEFIT MAXIMUMS	36
REINSTATEMENT OF LIFE TIME MAXIMUM.....	37
CONDITIONS OF COVERAGE	37
UTILIZATION REVIEW PROGRAM.....	37
THE MEDICAL NECESSITY REVIEW PROCESS	43
PERSONAL CASE MANAGEMENT	46
DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS	47
QUALITY ASSURANCE.....	48
MEDICAL CARE THAT IS COVERED.....	48
GENERAL EXCLUSIONS AND LIMITATIONS.....	63
PRE-EXISTING CONDITION EXCLUSION.....	68
REIMBURSEMENT FOR ACTS OF THIRD PARTIES	69
MCSIG PLAN ELIGIBILITY.....	70
WHEN BENEFITS BEGIN.....	70
TERMINATION OF BENEFITS	74
CONTINUATION OF GROUP COVERAGE.....	76
CONTINUATION FOR DISABLED DISTRICT EMPLOYEES	82
SURVIVOR BENEFITS	83
UNPAID LEAVE OF ABSENCE PROVISION.....	83
EXTENSION OF BENEFITS.....	84
COORDINATION OF BENEFITS.....	86
BENEFITS FOR MEDICARE ELIGIBLE MEMBERS	89
GENERAL PROVISIONS.....	90
BINDING ARBITRATION	97

HEALTH PROMOTION PROGRAM..... 98
WHO IS ELIGIBLE? 99
HOW DO I FIND OUT WHAT IS OFFERED? 99
WILL THE PROGRAM COST ME ANYTHING? 99
HOW DO I START? 99
HEALTH PROMOTION PROGRAM..... 93

SCHEDULE OF BENEFITS

	<i>EPO Participating Providers</i>	<i>EPO Non-Participating Providers</i>
Annual Deductible (Applies to all expenses unless otherwise noted. Does not include Office Visit, Emergency Room and Prescription Drug Co-payments.) See page ___ for additional information.	You pay \$650 per person or You pay two deductibles per family <i>(two individuals must meet their \$650 deductibles to satisfy the family deductible of \$1,300).</i> The non-participating provider annual deductible applies to emergency services only.	
Annual Out-of-Pocket Maximum (Includes deductible, excludes Office Visit and Prescription Drug Co-payments.)	You pay \$4,000 per person or \$8,000 per family (two individuals must meet their \$4,000 deductibles to satisfy the family deductible of \$8,000)	You pay unlimited.
Non-certification deductible (Does not apply to Out-of-Pocket Maximum.)	N/A	N/A
Lifetime Maximum	\$5,000,000	

	EPO Participating Providers	EPO Non-participating Providers
	You Pay	
Inpatient/Out-patient (see page ___)	20% of Prudent Buyer Plan negotiated rate, after deductible	100% except emergency
Ambulatory Surgical Center	20%, after deductible	100%
Emergency Room Visit Co-pay (Outpatient)	\$250 (waived if: (1) admitted directly from ER; or (2) true emergency per Anthem Blue Cross Life and Health medical policy; or (3) a medical advisory advised patient to call 911 or go to ER; or (4) diagnosis during ER visit was one of the five conditions managed by 360 Health and patient is enrolled and Participating in the 360 Health ConditionCare for this condition; or (5) diagnosis during ER visit was one of the five conditions managed by 360 Health and patient is not enrolled but subsequently enrolls in ConditionCare, and maintains the Participating status for at least one year after enrollment – see page ___ for more details)	If not a true emergency, you pay 100%.

	<i>EPO Participating Providers</i>	<i>EPO Non-Participating Providers</i>
	You Pay	
Medical Tourism program	No deductible for all surgeries performed through the plan's Medical Tourism Program.	
Physician Services		
Office Visit (Injections given in the office – i.e. Depro Vera – are paid the same as office visit)	\$25, deductible waived	100%
Home Visit	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Hospital Visit	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Specialist Office Visit	\$35, deductible waived	100%
Surgery	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Anesthesia	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Dental Care for Accidental Injuries to Natural Teeth (while covered under the plan) – see page _____	20%, deductible waived	100%

	<i>EPO Participating Providers</i>	<i>EPO Non-Participating Providers</i>
You Pay		
Durable Medical Equipment (limited to \$5,000 per calendar year – items costing \$2,000 or more must be pre-authorized (see page ___))	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Blood Transfusions	20% of Prudent Buyer Plan negotiated rate, deductible waived	100%
Prosthetic Devices (see page ___)	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Other Benefits		
Outpatient X-ray and Lab	20% of Prudent Buyer Plan negotiated rate, deductible waived	100%
Ambulance Service	20% of Prudent Buyer Plan negotiated rate after deductible	
Routine Physical Exam (members age 16 or over)	Nothing, up to \$250* for routine physical exams (Deductible does not apply). Limitations apply, see page ___)	100%
Well Baby and Well Child Care (Children under age 16) see page ___	Nothing (Office visit co-pay does not apply)	100%

	<i>EPO Participating Providers</i>	<i>EPO Non-Participating Providers</i>
	You Pay	
Other Benefits		
Physical Therapy, Physical Medicine and Occupational Therapy (Note – occupational therapy is limited to 24 visits per year. Additional visits are payable if prior authorization is obtained, and limited to \$25 for each authorized additional visit.)	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Maternity Care (see page ___)	Same as any other illness.	
Skilled Nursing Facility Maximum Benefit is 365 days per lifetime	20% of Prudent Buyer Plan negotiated rate after deductible up to 365 days per lifetime	100%
Home Health Care Maximum Benefit is 120 days per illness (see page ___)	20% of Prudent Buyer Plan negotiated rate after deductible up to 120 days per illness	100%

	<i>EPO Participating Providers</i>	<i>EPO Non-Participating Providers</i>
	You pay	
Other Benefits		
Hospice Care	Nothing, up to \$15,000 lifetime maximum benefit	
Outpatient Radiation, Chemotherapy and Hemodialysis (Deductible will apply)	20% of Prudent Buyer Plan negotiated rate after deductible	100%
Attention Deficit Disorder (see page ___). Maximum Benefit is \$2,000 per calendar year	20% of Prudent Buyer Plan negotiated rate, deductible waived	100%

	<i>OPTION III Participating Providers</i>	<i>OPTION III Non- Participating Providers</i>
Annual Deductible (Applies to all expenses unless otherwise noted. Does not include Office Visit and Prescription Drug Co-payments.) (See page 34 for additional information)	You pay \$650 per person or You pay two deductibles per family (two individuals must meet their \$650 deductibles to satisfy the family deductible of \$1,300)	
Annual Out-of-Pocket Maximum* (Includes deductible, excludes Office Visit and Prescription Drug Co-payments.)	You pay \$4,000 per person or \$8,000 per family	You pay \$7,000 per person or \$14,000 per family
Non-certification deductible (Does not apply to Out-of-Pocket Maximum.)	N/A	\$500 (waived for emergency)
Lifetime Maximum	\$5,000,000	

You may use any network provider at any time. All covered services, except for emergency, must be provided by Participating providers. No benefits are provided through this plan when you receive services from a non-participating provider, except for medically necessary covered services received for emergency care. If you utilize a non-participating provider this plan will pay no benefit and you will be responsible for paying for the provider's services out of your pocket.

If you are referred to another provider you are responsible for verifying whether that provider is participating or non-participating. If a participating provider refers you to a non-participating provider, you are responsible for the total amount billed by the non-participating provider (billed charges). Directories of participating providers are available online at www.anthem.com or through the MCSIG office. To get benefits paid through this plan you must only choose Participating providers from this list. It is always your obligation to be sure that the physician, hospital or other provider or facility you choose for treatment is a participating provider.

This plan is designed to reduce the cost of health care to you. In order to reduce your costs, much greater responsibility is placed on you.

Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial Hospital (SVMH) are NON-Participating providers in this EPO plan. There are no benefits payable under this plan if you utilize CHOMP or SVMH.

GENERAL INFORMATION

Purpose

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ("Anthem Blue Cross Life and Health") agrees to administer health care benefits for subscribers and dependents, defined herein as Members, of the Monterey County Schools Insurance Group ("MCSIG").

The Plan is maintained for the exclusive benefit of the Members and is intended to be maintained on an indefinite basis. In addition, the terms of the Plan, including coverage and benefits may be legally enforceable by the Plan Members.

Change or Discontinuance of Benefits

MCSIG may at any time change or discontinue the benefits provided by the Plan, but, no change or discontinuance may effect in any way the amount or terms of any benefits payment under the Plan prior to the date of such change or discontinuance.

DEFINITIONS

The terms and phrases in this Benefit booklet shall have the following meanings when used in this Benefit booklet unless a different meaning is clearly required by the context. Masculine pronouns include the feminine, plural nouns include the singular, and singular nouns include the plural, except where the context indicates otherwise.

Accident – A sudden, unexpected and unplanned event occurring by change which is caused by an independent external force and which results in definite physical trauma.

Accidental Injury – A physical harm or disability which is the result of an Accident. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Acupuncture - The services rendered by a licensed acupuncturist.

Agreement - refers to the self-insured program adopted by the Plan Administrator to provide Administrative Services Only to eligible Members.

Ambulatory Surgical Center – A freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care. It does not include the Physician's office in the outpatient department of a Hospital.

Anesthesia Services – The services of a Physician for administering an anesthetic in connection with surgical services. Not included are:

1. anesthetic administered by the operating physician or their assistant; or
2. local anesthetics.

Authorized Referral – This occurs when you, because of your medical needs, are referred to a Non-Participating Provider, but only when:

1. There is no Participating Provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
2. You are referred in writing to the Non-Participating Provider by the Physician who is a Participating Provider, and
3. We have authorized the referral before services are rendered.

Anthem Blue Cross Life and **Health Insurance Company (Anthem Blue Cross Life and Health)** is the company which administers the benefits of the *plan*.

Calendar Year (Year) – The period of time that begins each January 1 and ends the following December 31. Each like period which follows will be deemed a new Calendar Year.

Case Management - The process of working with a patient, the patient's family and Physicians to determine cost-effective alternatives to standard medical treatment. These alternatives must be Medically Necessary supplies or services.

Centers of Medical Excellence (CME) – Health care providers which have a Centers of Medical Excellence Agreement in effect with us at the time services are rendered. CME agree to accept the CME Negotiated Rate as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a CME. A provider's participation in the Prudent Buyer Plan network or other agreement with us is not a substitute for a Centers of Medical Excellence Agreement.

Centers of Medical Excellence Negotiated Rate (CME negotiated rate) – The fee CME agree to accept as payment for covered services. It is usually lower than their normal charge. CME negotiated rates are determined by Centers of Medical Excellence Agreements.

Child – The Subscriber’s child, stepchild or legally adopted child. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the Subscriber or Spouse have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption.

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

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, a Federal law (Title X of P.L. 99-272), as subsequently amended from time to time.

Contracting Hospital – A Hospital which has a Standard Hospital Contract in effect with us to provide care to Members. A contracting hospital is not necessarily a Participating Provider. A list of contracting hospitals will be sent on request.

Convalescent Care, Rehabilitation or Rehabilitative Care – Care furnished primarily to restore a Member’s ability to function as normally as possible after a disabling illness or injury.

Co-payment – Amount payable by the Member for certain services provided by Network Providers. The co-payment must be paid each time a service is performed. The co-payment will not be applied to the coinsurance maximum and any deductible amount.

Note. Percentage Co-payment was previously defined as Coinsurance on the MCSIG’s self insured plan.

Cosmetic Surgery – Beautification or aesthetic surgery designed to improve the appearance of a Member by a surgical alteration of a physical characteristic which is within the broad range of normal, but, which is considered unpleasing or unsightly.

Covered Charges – As allowed under the Plan, the actual charges for covered services and supplies, but, not more than the maximum amounts described in this Benefit booklet. For Participating Providers, it is based on the Negotiated Rate and for non-participating providers, it is not more than the Customary and Reasonable Charge for such services and supplies, whichever is less. Covered charges are incurred on the date the Member receives the service or supply.

Covered Services and Supplies – Services and supplies for which benefits are payable under the Plan.

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

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

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

Custodial Care – Care provided primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a Physician) or care provided to a Member who is mentally or physically disabled; and

- a. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the Member to live outside an institution providing such care; or
- b. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Customary and Reasonable Charge (C & R) – As determined annually by Anthem Blue Cross Life and Health Insurance Company, is a charge which falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Deductible – The amount of Covered Charges that must be paid by a Member before a claim is considered for payment by the Plan.

Dependent –

1. The Subscriber's lawful Spouse of the opposite sex;
2. Domestic Partner;
3. Any unmarried Child of either or both the Subscriber, Spouse or Domestic Partner who is under age 19;
4. Any unmarried Child who is age 19 through 24 years who qualifies as a full-time student as defined in the Federal Income Tax Code. However, coverage will continue for six months following graduation, or employment with benefits, whichever occurs first. We must receive this information in writing; or

5. Any unmarried Child who is and continues to be both:
 - a. incapable of self-sustaining employment by reason of mental or physical handicap; and
 - b. chiefly dependent upon the Subscriber for economic support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan by the Subscriber within 90 days of the child's attainment of the limiting age, and subsequently as may be required by the Plan, but, not more frequently than annually after the two-year period following the child's attainment of the limiting age. The Plans determination of eligibility shall be final and conclusive; or
6. Newborns for the first 31 days of life for illness or injury, provided the Subscriber or Dependent Spouse is covered at the time of birth. Coverage after 31 days is contingent upon the Subscriber enrolling the newborn as a dependent within 31 days following birth.

Disability – An injury, an illness or a condition (including pregnancy), however:

1. all injuries sustained in any one accident will be considered one disability;
2. all illness existing simultaneously which are due to the same or related causes will be considered one disability; and
3. if any illness is due to causes which are the same as, or related to, the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

Durable Medical Equipment – Dialysis equipment; dialysis supplies and other medical equipment and supplies which are:

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

Durable Medical Equipment are designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body part, or to prevent further deterioration of the Member's medical condition. Durable Medical Equipment includes items such as wheelchairs, hospital beds, respirators, and other equipment that the Plan determines are primarily used for medical care.

Effective Date – The date Member's coverage begins under this Plan.

Emergency – A sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with us. Also, accidental injury within 24 hours is covered.

Emergency Care – Those services required for the immediate diagnosis and treatment of an accidental injury or an unforeseen medical condition which, if not immediately diagnosed and treated, could lead to permanently placing the Member's health in jeopardy, serious impairment of any body part, other serious medical consequences, or death.

Subscriber – An individual who meets the eligibility requirements for medical coverage, for his or her classification, established by the School District, for which he or she is employed, that is participating in the Monterey County Schools Insurance Group.

Experimental or Investigative – Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition. Services which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Services which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational.

Home Health Agencies and Visiting Nurse Associations – An agency approved as home health care under Medicare, or established and operated with the applicable laws in the jurisdiction in which it is located, and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law, or meets all of the following requirements:

- a. it is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
- b. it has a full-time administrator;
- c. it maintains written records of services provided to the patient;
- d. its staff includes at least one registered graduate nurse (RN) or it has nursing care by an RN available.

Home Infusion Therapy Provider – A provider licensed according to state and local laws as a pharmacy that is either certified as a home health care provider by Medicare or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice – An agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals; (4) providing service 24 hours a day, 7 days a week; (5) under the direct supervision of a Physician; (6) with a nurse coordinator who is a registered nurse (RN); or (7) with a full-time administrator. A list of hospices meeting these criteria is available upon request.

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

For the limited purpose of inpatient care for the acute phase of a Mental Or Nervous Disorder, “Hospital” also includes Psychiatric Health Facilities.

Illness - Sickness or disease, non-congenital organic mental disorders, or pregnancy of a Member which results in a loss covered by the Plan.

Incurred - A charge shall be deemed to be “incurred” on the date the particular service or supply is provided or obtained.

Inpatient - A Member who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

Insurance Carrier - An insurance company that is qualified to engage in the business of insurance in at least one state of the United States, and that is permitted to hold assets of an employee benefit plan, free of trust.

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

JPA – A Joint Powers Authority, by state legislation, allowing public entities to join together for the purpose of pooling resources and obtaining greater purchasing power for insurance products. The Monterey County Schools Insurance Group is a JPA. When reference is made to a JPA in this booklet, it will refer to the Monterey County Schools Insurance Group.

Late Applicant – An otherwise eligible Subscriber or Dependent enrolling in the Plan after that individual’s enrollment period has expired as established by their School District for their classification.

Leave of Absence (LOA) – An authorized absence approved by a subscriber’s School District under the JPA for a specific period of time.

Medically Necessary – Those services or supplies we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;

3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your Physician or another provider; and
5. The most appropriate supply or level of service which can safely be provided. The most appropriate service or supply must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the service or supply are clinically significant and produce a greater likelihood of benefit for you with the particular medical condition being treated than other possible services or supplies; and
 - b. The service or supply is no more likely to be harmful to you than other services or supplies that could be prescribed under the same circumstances; and
 - c. For Hospital Stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

In determining medical necessity, we will take into account the results of a review by our medical directors and/or by independent medical professionals selected by us, including professionals who treat the type of disease or condition involved.

Medicare – Part A and Part B Plans as described in Title XVIII of the United States Social Security Act as amended.

Member – A subscriber, and their Dependents, who have completed any necessary waiting period and meet any eligibility requirements set by the Subscriber's employer and the Plan.

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

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

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

Negotiated Rate – The amount Participating Providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements.

Non-Contracting Hospital – A Hospital which does not have a Standard Hospital Contract in effect with us at the time services are rendered.

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

Non-Participating Provider – One of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

1. A Hospital;
2. A Physician;
3. An Ambulatory Surgical Center;
4. A Home Health Agency or Visiting Nurse Association;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A Skilled Nursing Facility;
8. A clinical laboratory; or
9. A Home Infusion Therapy Provider.

They are not Participating Providers. Remember there is no benefit through this plan for services at Non-participating providers.

The following two providers – Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial Hospital (SVMH) – are **Non-participating** providers for purposes of this plan. There is no benefit payable for services provided by CHOMP/SVMH. See ER coverage for emergency coverage at these two hospitals.

Other Health Care Provider – One of the following providers:

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

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

Outpatient - A Member who has not been admitted to a Hospital as a registered bed patient but is receiving Hospital services under the direction of a Physician.

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

Participating Provider – One of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

1. A Hospital; (but not Community Hospital of the Monterey Peninsula or Salinas Valley Memorial Hospital)
2. A Physician;
3. An Ambulatory Surgical Center;
4. A Home Health Agency or Visiting Nurse Association;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A Skilled Nursing Facility;
8. A clinical laboratory; or
9. A Home Infusion Therapy Provider.

Participating Providers agree to accept the Negotiated Rate as payment for covered services. A directory of Participating Providers is available on the website at www.MCSIG.com or upon request by calling customer service.

Pharmacy means a licensed retail pharmacy.

Physician – A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

Services by one of the following providers, but, only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:

- a. A dentist (D.D.S.)
- b. An optometrist (O.D.)
- c. A dispensing optician
- d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- e. A psychologist*
- f. A chiropractor (D.C.)*

In addition, services by one of the following providers, but, only by referral of a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) as defined above:

- a. A clinical social worker (L.C.S.W.)*
- b. A marriage, family and child counselor (M.F.C.C.)*
- c. A physical therapist (P.T. or R.P.T.)
- d. A speech pathologist
- e. An audiologist
- f. An occupational therapist (O.T.R.)
- g. A respiratory care practitioner (R.C.P.)
- h. A Psychiatric Mental Health Nurse (R.N.)

- i. A nurse midwife**

*You **must** use network providers for Chiropractic and Behavioral Health/Substance Abuse benefits. Chiropractic and Behavioral Health/Substance Abuse benefits are provided through a separate (non-Anthem Blue Cross) provider network (see pages 29 & 30). There are no out of network benefits for these services.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the customer service telephone number on your ID card for a list of OB/GYN providers.

Plan is the set of benefits described in this benefit booklet and in the amendments to this *benefit booklet*, if any. These benefits are subject to the terms and conditions of the *plan*. If changes are made to the plan, an amendment or revised *benefit booklet* will be issued to each *subscriber* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Plan Year - The 12 consecutive month period beginning each January 1.

Pre-existing Condition – An illness, injury or condition which existed during the six-month period immediately prior to your becoming eligible. A condition is considered to have existed when you: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.

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

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

Reasonable Charge – A charge we consider not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Re-enrollment - During the month of November, Subscribers, if their school district office optional plans, will have an opportunity to change to a different MCSIG medical plan. Changes will be effective the following January 1.

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

Special Care Units – Special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse – A person who meets the Plan’s eligibility requirements for spouses as outlined under MCSIG PLAN ELIGIBILITY.

Stay – A continuous hospital confinement or a series of confinements that are separated by less than 28 days between discharge and readmission; however, if readmission is necessary within 28 days of discharge because of an accidental injury, a new period of disability will begin for that injury.

Subscriber – An individual who meets the eligibility requirements for medical coverage, for his or her classification, established by the School District, for which he or she is employed, that is participating in the Monterey County Schools Insurance Group.

Surgical Procedure – Cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution and most invasive procedures.

Total Disability –

1. With respect to a subscriber or person otherwise eligible for coverage as a subscriber, a disability which prevents the Member, as a result of bodily injury or disease, from engaging in any employment or occupation for which the Member is or becomes qualified by reason of education, training or experience and engaging in any employment or occupation for wage or profit in which the Member reasonably might be expected to engage, in view of the Member’s station in life and mental capacity;
2. With respect to a Dependent, a disability which prevents the individual from performing all regular and customary activities usual for a person of that age and family status.

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

Urgent Care Center - A facility that meets professionally recognized standards and all of the tests that follow:

- a. It mainly provides urgent or emergency medical treatment for acute medical conditions; and
- b. It does not provide services or accommodations for overnight stays; and
- c. It is open to receive patients each day of the calendar year; and
- d. It has on duty at all times a Physician trained in Emergency medicine and nurses and other supporting personnel who are specifically trained in emergency care; and it has x-ray and laboratory diagnostic facilities and emergency equipment, trays and supplies for use in life-threatening events.

Utilization Review (UR) – The process of reviewing the appropriateness and the quality of care provided to patients. UR may be done before (pre-service review), during (concurrent review) or after (retrospective review) the services are rendered.

HOW TO USE YOUR PLAN

MEDICAL BENEFITS

INTRODUCTION

You have chosen a Plan that provides no benefit when you use Non-participating providers. You may, however, use any licensed provider you wish, anytime. If you utilize a Non-participating provider this plan will pay no benefit and you will pay out-of-pocket. Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial Hospital (SVMH) are considered Non-participating providers for purposes of this plan. This plan will pay no benefit if you use CHOMP or SVMH. See ER coverage for emergency coverage at CHOMP or SVMH.

For Chiropractic or Behavioral Health/Substance Abuse benefits, contact MCSIG Customer Service for information on Participating Providers or see page 30.

HOW TO USE THE PRUDENT BUYER PROVIDER NETWORK

Present your identification card to the provider of the service and confirm that they are a Prudent Buyer Provider. Your ID Card will identify you and your Dependents as enrolled in EPO Plan. All Prudent Buyer providers are familiar with the Plan requirements and will follow the Plan rules.

WHY YOU SHOULD USE PARTICIPATING PROVIDERS:

NO PLAN BENEFITS IF YOU USE NON-PARTICIPATING PROVIDERS – This plan provides no benefits if you use Non-participating providers. If you utilize a Non-participating provider this plan will pay no benefit and you will pay out-of-pocket. Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial Hospital (SVMH) are Non-participating providers for purposes of this EPO plan. This plan will pay no benefit if you use CHOMP or SVMH. See ER coverage for emergency coverage at CHOMP or SVMH.

NO CLAIM FORMS – You do not have to submit claims. Participating Providers have agreed to bill directly. Your Explanation of Benefits (EOB) will show the breakdown of the charges and what part of the charges you have to pay. Participating Providers should only bill you for your share, if any, of the cost.

UTILIZATION REVIEW AND AUTHORIZATION PROGRAMS – Participating Providers will arrange for any required utilization reviews and authorized referrals you require in connection with your medical care.

WHAT SERVICES REQUIRE PRIOR APPROVAL?

All inpatient Hospital Stays

Outpatient surgery at an Ambulatory Surgical Center

Organ and tissue transplants

Additional visits for physical therapy, physical medicine and occupational therapy

Home infusion Therapy

Admissions to Skilled Nursing Facility

Home Health Care

Coronary Artery Bypass Graft

Bariatric Surgery

DME for any item costing \$2,000 or more

CAN I GO DIRECTLY TO A SPECIALIST?

Yes.

ARE THERE PARTICIPATING PROVIDER BENEFITS WHEN OBTAINING CARE OUT-OF-STATE?

Yes. But, the type of care you receive depends on whether the services you need are for Emergency Care, Urgent Care or just regular care.

If you require Emergency Care or Urgent Care, you may go to any physician or hospital for treatment. For the initial treatment of the condition causing the emergency or urgent care situation, benefits will be the same as Participating Providers under the Prudent Buyer Plan.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which we contract with, has a program (called the “BlueCard Program”) which allows our Members to have the reciprocal use of participating providers contracted under other states’ Blue Cross and/or Blue Shield Plans. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider which does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to the available discounts, we must abide by those rules.

When you obtain services outside California, your coinsurance and other subscriber liability for covered services is calculated on the lower of the actual billed charges for your covered services or the negotiated price that is passed along to Anthem Blue Cross by the local Blue Cross and/or Blue Shield Plan. The negotiated price can simply reflect the final actual discount on a claim. Often the negotiated price will consist of an estimated final price to reflect contractual adjustments that will occur at a later date. The estimated price may be based on the expected adjustment for the particular provider involved or for all or a specified group of the local Plan’s providers. Also in a small number of states, your coinsurance and other subscriber liability for covered services will be calculated using a discount off billed charges that is an average discount reflecting the local Plan’s anticipated savings for all or a specified group of its providers. Estimated or average prices may be prospectively adjusted to correct for overestimation or underestimation of past prices.

Finally, local Blue Cross and/or Blue Shield Plans in a small number of states are required by statute to use a basis for calculating subscriber liability for covered items that does not reflect the entire savings realized, or expected to be realized on the claim. When you receive covered health care services in one of these states, your liability for covered services will be calculated using the state’s statutory methods.

If you require additional care after the initial treatment for the condition causing the emergency or urgent care situation, you need to follow the rules for the Blue Card Program.

The Blue Card Program, as previously described, can provide you with Emergency Care, Urgent Care or routine care while you are outside of California.

WHAT IF I REQUIRE MEDICAL ATTENTION WHEN MY DOCTOR'S OFFICE IS CLOSED?

If you need Emergency Care, you should get immediate medical attention. You will receive regular Prudent Buyer EPO Option benefits for the treatment of an Emergency. Non-emergency care or subsequent and/or follow-up services at a non-participating provider beyond those services required to treat the Emergency are not covered. This Plan will provide benefits if you require transport to a Participating facility for medical services immediately subsequent to Emergency Care.

In any case, you should try if possible, to use Prudent Buyer Providers (Participating Providers). You should not assume just because you are in a Hospital, or other facility, which is a Prudent Buyer Participating Provider that all physicians in the facility are Prudent Buyer Participating Providers. If services are rendered by a Non-participating Physician who is hospital-based or on-call, you will receive regular Prudent Buyer EPO Option benefits for the initial treatment of the Emergency condition.

If you require Urgent Care, you may go to any provider for services. However, you will only receive benefits if you go to a Prudent Buyer Participating Provider.

WHERE DO I GO FOR LABORATORY SERVICES?

Generally, if you need diagnostic x-ray or laboratory services, your Participating Provider will send you to a Participating Provider facility for the required services. In some instances, a Participating Provider may do some of the x-ray or lab work in their office.

WHERE TO CALL WHEN YOU HAVE A QUESTION OR PROBLEM:

If you have a question regarding your benefits, eligibility or a claim, call:

MCSIG Customer Service at 831-755-8055 or toll free at 800-287-1442

Prescription Drugs, See page 31

To contact OptumHealth Behavioral Solutions (mental health & employee assistance), Call 800-998-8448

To contact OptumHealth Behavioral Solutions (Behavioral Health/Substance Abuse and Employee Assistance), Call 800-998-8448

To contact Chiropractic Health Plan of California directly, Call 800-995-2442

HOW TO FILE AN APPEAL OF ELIGIBILITY, BENEFITS OR TREATMENT

If you have a question about your eligibility, your benefits under this Plan, or concerning a claim, please call the telephone number listed on your identification card, or you may write to MCSIG (please address your correspondence to MCSIG, 76 Stephanie Drive, Salinas, CA 93901) marked to the attention of the Customer Service Department). Our customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form to complete and return to us, or ask the customer service representative to complete the form for you over the telephone. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. After we have reviewed your grievance, we will send you a written statement on its resolution or pending status. If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited.

ADDITIONAL BENEFITS

The benefits listed below are for Behavioral Health/Substance Abuse Care, Chiropractic Care, Life Insurance, Vision Care and Dental Care and are not provided or administered by Anthem Blue Cross Life and Health. For information on any of the listed additional benefits, contact MCSIG at 1-800-287-1442.

BEHAVIORAL HEALTH/SUBSTANCE ABUSE

ALL behavioral health care, including substance abuse, is provided through PacificCare Behavioral Health. If treatment for behavioral health/substance abuse care (i.e., stress, depression, etc.) is obtained without a referral to PacificCare Behavioral Health you MAY be responsible for the charges incurred. The Plan will pay your Physician for the visit in which they make the diagnosis of a behavioral health/substance abuse problem, but not for additional visits to treat the mental condition.

See the Description of Benefits section of this booklet or refer to the Benefit booklet provided by PacificCare Behavioral Health (available through your School District Office).

If you are in need of these services, call PacificCare Behavioral Health at 1-800-998-8448. They are available 24-hours a day, seven days a week.

CHIROPRACTIC CARE

NOTE: This plan does NOT cover services by non-network chiropractors.

Chiropractors are in a different network contracted through the Chiropractic Health Plan of California (CHPC). A directory of those providers is also available through your School District Office. Network Chiropractors have agreed to prepare and submit a treatment plan to the Chiropractic Health Plan of California office for approval when treatment begins.

Chiropractic doctors are also available nationally. If you live outside of Monterey County, call 1-800-995-2442 for a directory of chiropractors in your area. Remember, the Plan only covers chiropractic care when provided by a network provider.

ACUPUNCTURE CARE

The plan covers any Licensed Acupuncturist. Payment is limited to \$65 per visit, up to 30 visits per calendar year.

PRESCRIPTION DRUG PROGRAM

YOUR PRESCRIPTION DRUG PROGRAM are provided by EXPRESS SCRIPTS INC. Please call Customer Service at 1-866-321-9650 (under age 65) or 1-866-312-7239 (over age 65) for prescription drug information.

LIFE INSURANCE

Every employee who is covered for medical benefits also has group term life insurance coverage. This coverage is provided through Prudential Life Insurance Company of America at a base amount of \$25,000. The amount of your life insurance may vary depending on your school district.

VISION CARE

If provided through your School District, the vision care benefit for covered services is available through Vision Service Plan. An application to request services is available through your School District's benefits department or by calling 800-877-7195. The Plan requires approval from Vision Service Plan before obtaining vision care services.

DENTAL CARE

If provided through your School District, the dental care benefit for covered services is available through Delta Dental. See your School District's benefits department for a description of coverage or you may call Delta Dental directly at 888-335-8227.

MEDICAL TOURISM BENEFIT

Procedures provided through this plan's medical tourism benefit will not be subject to the annual deductible or co-payment provisions of the plan. In addition, reasonable travel costs for the patient and one companion will be arranged by, and paid for, through the medical tourism benefit. Call MCSIG Customer Service at 800-287-1442 for more information.

CENTERS OF MEDICAL EXCELLENCE.

The following separate Centers of Medical Excellence (CME) networks have been established. The facilities included in each of these CME networks provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Subject to any applicable co-payments or deductibles, these CME's agree to accept the CME negotiated rate as payment in full for covered services. These procedures are covered only at a CME.
- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. These procedures are covered only at a CME.
- **Coronary Artery Bypass Graft (CABG) Facilities.** Hospital facilities have been organized to provide services for coronary artery bypass graft surgical procedures. **These procedures are covered only at a CME.**

A participating provider in the Prudent Buyer Network is not necessarily a CME facility. Please call MCSIG Customer Service at (800) 287-1442 for a list of CME facilities for a specific service.

MCSIG MESSAGE

To keep you informed of any changes in your Plan of benefits, the MCSIG office produces a quarterly newsletter called the *MCSIG MESSAGE*. MCSIG sends this newsletter to the homes of all Members. Please read these newsletters carefully to learn of any changes in benefits that may affect you.

We encourage you to save the newsletters because important information may not apply to you now, but, may apply to you later.

DESCRIPTION OF BENEFITS

MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

We will pay for Covered Medical Expenses you incur under this Plan. A charge is incurred when the service or supply giving rise to the charge is rendered or received. Covered Expense for medical benefits is based on a maximum charge for each covered service or supply that will be accepted by us for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and CME. The maximum Covered Expense for services provided by a Participating Provider or CME will be the lesser of the billed charge or the Negotiated Rate. Participating Providers and CME have agreed not to charge you more than the Negotiated Rate for covered services. When you choose a Participating Provider, you will not be responsible for any amount in excess of the Negotiated Rate. If you receive an authorized, specified organ transplant at a CME, you will not be responsible for any amount in excess of the CME Negotiated Rate for the covered services of a CME.

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

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an Ambulatory Surgical Center. An Ambulatory Surgical Center is licensed as a separate facility even though it may be located on the same grounds as a Hospital (although this is not always the case). If the center is licensed separately, you should find out if the facility is a Participating Provider before undergoing the surgery.

Non-participating Providers and Other Health Care Providers. This plan does not pay benefits for charges incurred by the member through utilization of Non-participating providers. If you utilize Non-participating providers you will be responsible for the providers full billed charges. In the event of Emergency, all hospital-based Physician charges in connection with the treatment for your emergency condition will be paid at the in-network level of payment.

You will always be responsible for expenses incurred which are not payable under this Plan.

Exception: If Medicare is the primary payor, Covered Expense does not include any charge:

1. By a Hospital, in excess of the approved amount as determined by Medicare; or
2. By a Physician or Other Health Care Provider, in excess of the lesser of the maximum Covered Expense stated above, or:
 - a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
 - b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

You will always be responsible for expenses incurred which are not payable under this Plan.

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

After we subtract any applicable deductible and your Co-Payment, we will pay benefits up to the amount of Covered Expense, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the Schedule Of Benefits.

DEDUCTIBLES

Each deductible under this Plan is separate and distinct from the other. Only charges that are considered Covered Expense will apply toward satisfaction of any deductible.

Calendar Year Deductible. Each Year, you will be responsible for satisfying the Individual's Calendar Year Deductible before we begin to pay benefits.

Family Deductible. The first two Members of an enrolled family who satisfy their Calendar Year Deductibles will satisfy the Family Deductible. Once the Family Deductible is satisfied, no further Calendar Year Deductible expense will be required for any enrolled member of that family.

Covered expense incurred from October through December and applied toward the Calendar Year Deductible for that Year also counts toward the Calendar Year Deductible for the next Year.

Prior Plan Calendar Year Deductibles. If you were covered under a Prior Plan any amount paid during the same Calendar Year toward your calendar year deductible under the Prior Plan, will be applied toward your Calendar Year Deductible under this Plan; provided that, such payments were for charges that would be Covered Expense under this Plan.

Additional Deductibles

1. Each time you visit an emergency room for treatment you will be responsible for paying the **\$250** Emergency Room Co-Payment. The emergency room co-payment does **NOT** accrue to your annual deductible or out-of-pocket maximum. The emergency room co-payment may be waived or reimbursed, with appropriate proof, under the following circumstances:
 - a. The reason for the emergency room visit meets the definition of “Emergency” under the DEFINITIONS section of your PPO medical plan booklet (this booklet).
 - b. The patient was immediately admitted into a hospital from the emergency room.
 - c. A medical provider advised patient to call 911 or go to the emergency room.
 - d. The emergency room visit was for the diagnosis and/or treatment of any life threatening symptom associated with any of the ConditionCare Primary Conditions (Asthma, Coronary Artery Disease, Heart Failure, Chronic Obstructive Pulmonary Disease and Diabetes) AND
 - i. The patient is currently enrolled and actively participating in the ConditionCare Program., or
 - ii. The patient subsequently immediately enrolls in the ConditionCare program and actively participates for one year (co-pay to be refunded at the end of the year).
2. Each time you are admitted to a Hospital or Ambulatory Surgical Center without properly obtaining certification, you are responsible for paying the **\$500** Non-Certification Deductible. This deductible will not apply to an Emergency admission or procedure, nor to services provided at a Participating Provider. Certification is explained in the Utilization Review Program.

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment from the amount of Covered Expense remaining.

We will apply the applicable percentage to the amount of Covered Expense remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Maximum. If, after you have met your Calendar Year Deductible, you pay Coinsurance equal to your Out-of-Pocket Amount during a Calendar Year, you will no longer be required to pay Co-insurance for any Covered Expense you incur during the remainder of that Year, other than for office visits to a Physician who is a Participating Provider.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-of-Pocket Amount:

- Charges which are not considered Covered Expense; and
- Co-payments for office visits to a Physician who is a Participating Provider.

Participating Providers, CMEs and Other Health Care Providers. Only Covered Expense for the services of a Participating Provider, CME or Other Health Care Provider will be applied to the Participating Provider and Other Health Care Provider Out-of-Pocket Amount.

After this Out-of-Pocket Amount has been satisfied during a Calendar Year, you will no longer be required to pay any Co-insurance for the covered services provided by a Participating Provider, CME or Other Health Care Provider for the remainder of that Year.

Non-participating Providers. This plan does not pay benefits for charges incurred by the member through utilization of Non-participating providers. If you utilize Non-participating providers you will be responsible for the provider's full billed charges. In the event of Emergency, all hospital-based Physician charges in connection with the treatment for your emergency condition will be paid at the in-network level of payment.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any Member in excess of any of the Medical Benefit Maximums. Your \$5,000,000 Lifetime Maximum under this Plan will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by Anthem Blue Cross Life and Health, or any of its affiliates, which is sponsored by MCSIG. This amount also includes any benefits paid by Medicare that would have been paid to a Member without Medicare.

Reinstatement of Life Time Maximum

On the last day of a Calendar year, up to \$1,000 will be restored automatically to a Member's Lifetime Maximum if benefits have been provided for covered services and supplies. This provision will not apply if the Member is receiving benefits under the Extension of Benefits provision.

CONDITIONS OF COVERAGE

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

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

UTILIZATION REVIEW PROGRAM

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

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

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

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays*.
- Outpatient surgery at an *ambulatory surgical center*
- Organ and tissue transplants.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Coronary Artery Bypass Graft performed at a Center of Expertise
- Bariatric surgical services performed at a Centers of Medical Excellence

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

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

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
 - Scheduled, non-emergency inpatient *hospital stays* (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
 - Outpatient surgery at an *ambulatory surgical center*
 - Organ and tissue transplants.
 - Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Home infusion therapy.
 - Home health care.
 - Admissions to a *skilled nursing facility*.
 - Coronary Artery Bypass Graft performed at a Center of Expertise
 - Bariatric surgical services performed at a Centers of Medical Excellence
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when the *claims administrator* is notified while service is ongoing, for example, an emergency admission to the hospital.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* admission, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Organ and tissue transplants as follows:
 - a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Medical Excellence (CME)* facility.
 - A specified number of additional visits for physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Physical Therapy, Physical Medicine or Occupational Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
 - Home health care services if:
 - a. The services can be safely provided in your home, as certified by your attending *physician*;
 - b. Your attending *physician* manages and directs your medical care at home; and
 - c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.

- Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Coronary Artery Bypass Graft. Authorization for all non-emergency coronary artery bypass graft surgical procedures required. These are the conditions that have to be met in order for these non-emergency services to be covered:
 - a. The services are medically necessary and appropriate; and
 - 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 non-emergency Coronary Artery Bypass Graft procedure must be performed at a *Centers of Medical Excellence (CME)*.
- Bariatric Surgery. Authorization for all bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss is required. These are the conditions that have to be met in order for these services to be covered:
 - a. The services are *medically necessary* and appropriate; and
 - b. The services are to be performed for the treatment of morbid obesity; and
 - c. 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; and
 - d. The bariatric surgical procedure must be performed at a *Centers of Medical Excellence (CME)*.

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* directly. The toll-free number for pre-service review is printed on your identification card.
3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. The *claims administrator* will determine if services are *medically necessary* and appropriate. For inpatient *hospital*, the *claims administrator* will, if appropriate, specify a specific length of *stay* for services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.
2. When participating providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.
3. When it is determined that the service is *medically necessary* and appropriate, the *claims administrator* will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.

4. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. You and your *physician* will receive written notice within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

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

Retrospective Reviews

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

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

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

THE MEDICAL NECESSITY REVIEW PROCESS

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

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.
4. If the *claims administrator* does not have the information they need, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,
 - reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

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

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

PERSONAL CASE MANAGEMENT

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

HOW PERSONAL CASE MANAGEMENT WORKS

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

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

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

Alternative Treatment Plan. If the *claims administrator* determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this *plan*. A case manager will review the medical records and discuss your treatment with the attending *physician*, you, and your family.

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

EFFECT ON BENEFITS

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

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

QUALITY ASSURANCE

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

MEDICAL CARE THAT IS COVERED

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

Hospital –

1. Inpatient services and supplies, provided by a Hospital. Covered Expense will not include charges in excess of the Hospital's prevailing two-bed room rate unless there is a negotiated per diem rate between us and the Hospital, or unless your Physician orders, and we authorize, a private room as Medically Necessary.
2. Services in Special Care Units.
3. Outpatient services and supplies provided by a Hospital, including outpatient surgery.

Skilled Nursing Facility – Inpatient services and supplies provided by a Skilled Nursing Facility, for up to 365 days per lifetime. The amount by which your room charge exceeds the prevailing two-bed room rate of The Skilled Nursing Facility is not considered Covered Expense. A Member must be transferred directly from a covered inpatient stay to the skilled nursing facility. Skilled Nursing Facility services and supplies are subject to prior authorization to determine medical necessity.

Home Health Care – The following services provided by a Home Health Agency or Visiting Nurse Association:

1. Services of a registered nurse.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a Home Health Agency or Visiting Nurse Association. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency or Visiting Nurse Association as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. Medically Necessary supplies provided by the Home Health Agency or Visiting Nurse Association.

In no event will benefits exceed 120 days per illness.

Home health care services are subject to prior authorization to determine medical necessity.

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

Hospice Care – We will pay up to a maximum of **\$15,000** during your lifetime for:

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

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

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 us every 30 days.

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

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

Home Infusion Therapy Provider services are subject to prior authorization to determine medical necessity.

Ambulatory Surgical Center – Services and supplies provided by an Ambulatory Surgical Center in connection with outpatient surgery.

Professional Services –

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

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.

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

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

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

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices –

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. The *plan* will pay for other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes;
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
 - d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
 - e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

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

Benefits will be limited to \$5,000 per calendar year. Items costing \$2,000 or more must be pre-authorized. We will determine whether the item satisfies the conditions above.

Blood – Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure. Reasonable shipping fees are also covered if Medically Necessary.

Dental Care – Services of a Physician (M.D.) or dentist (D.D.S.) treating an Accidental Injury to natural teeth which occurs while you are covered under the Agreement. Services must be received during the six months following the date of injury. Damage to natural teeth due to chewing or biting is not Accidental Injury.

Pregnancy and Maternity Care –

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

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

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

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

Covered Expense does not include charges for services received without first obtaining our prior authorization, or which are provided at a facility other than a transplant center approved by us. See COST CONTAINMENT: AUTHORIZATION PROGRAM for details.

You must obtain our prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to preoperative tests and postoperative care. Specified organ transplants must be performed at A Center Of Expertise (CME).

Organ and Tissue Transplant Travel Expense – The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a CME, provided the expenses are authorized by us (for authorization, please call the toll free number at 1-800-274-7767):

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
 - a. Round trip coach airfare to the CME.
 - b. Hotel accommodations.
 - c. Other expenses, such as meals and auto mileage.
2. For the donor, per transplant episode, limited to one trip:
 - a. Round trip coach airfare to the CME.
 - b. Hotel accommodations.
 - c. Other expenses, such as meals and auto mileage.

A travel reimbursement form will be provided for the submission of legible copies of all applicable receipts in order to obtain reimbursement to all travel benefits.

Coronary Artery Bypass Graft. Services and supplies in connection with coronary artery bypass graft surgery only when performed at an approved CME facility.

Covered Expense does not include charges for services received without first obtaining our prior authorization.

You must obtain our prior authorization for all coronary artery bypass graft surgical procedures. Such prior authorization procedures will only apply to services received on a non-emergency basis. See UTILIZATION REVIEW PROGRAM for details.

CABG Travel Expense. The following expense benefits will be provided in connection with a covered CABG surgical procedure only when the insured person's home is fifty (50) miles or more from the approved CME. All travel expenses must be approved by Anthem Blue Cross Life and Health in advance.

- Transportation for the *member* to and from the CME up to \$130 per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).

- Transportation for one companion to and from the CME up to \$130 per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the member and one companion not to exceed \$100 per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as medically necessary. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to four (4) days per trip. Tobacco, alcohol and drug expenses are excluded from the coverage.

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

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at an approved *CME* facility.

The Calendar Year Deductible will not apply to bariatric expense in connection with an authorized bariatric surgical procedure provided at an approved *CME*.

Your Co-Payment for bariatric surgical procedures authorized by us and performed at a designated *CME* will be zero. **Services for bariatric surgical procedures are not covered when performed at other than a designated *CME*.** See UTILIZATION REVIEW PROGRAM.

You must obtain our prior authorization for all bariatric surgical procedures.

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the *member's* home is fifty (50) miles or more from the nearest bariatric *CME*. All travel expenses must be approved by the *claims administrator* in advance. The fifty (50) mile radius around the *CME* will be determined by the *bariatric CME coverage area*. (See DEFINITIONS.)

- Transportation for the patient and companion to and from the *CME* up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *CME* up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Tobacco, alcohol and drug expenses are excluded from coverage.

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

Travel Expense For Out of Area Surgery (Other than Transplant, CABG, or Bariatric).

For the companion to patient when traveling to have surgery at a *CME* which is more than 50 miles from the covered person's home:

- a. Lodging – Up to three nights, actual cost up to \$100 per night with receipt. After three nights, the claimant can request a higher reimbursement based upon the prevailing rate for the area in the near vicinity of the hospital, as per a quarterly review of the *CME* recommended accommodations' rates.
- b. Meals -- \$32 per diem
- c. Parking – Actual expense fee (actual receipt is required)
- d. Mileage –Not Covered

A travel reimbursement form will be provided for the submission of legible copies of all applicable receipts in order to obtain reimbursement.

Attention Deficit Disorder – Covered services shown below for the treatment of attention deficit disorder (ADD), also known as Hyper-Kinetic Syndrome (HKS), including prescription drugs for the treatment of ADD or HKS. Benefits are not provided for special schooling, hospital stays, counseling, diagnostic testing, other than initial diagnosis, or for experimental treatment.

Well Baby and Well Child Care – The following services for a dependent Child under 16 years of age:

1. A Physician’s services for routine physical examinations
2. Immunizations given as standard medical practice for children. You will not have to pay an office co-payment for immunizations provided by a Participating Provider.
3. Radiology and laboratory services in connection with routine physical examinations.

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

Routine Physical Exam - In addition to any services specified elsewhere in the Benefit booklet, we will pay up to **\$250**, according to the following table, for the following services:

1. A Physician’s services for routine physical examinations.
2. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination.

Member’s Age	Frequency of Routine Physical Exams
Less than 35	Once every 5 Years (60 months)
35, but, less than 45	Once every 3 years (36 months)
45, but, less than 55	Once every 2 years (24 months)
55 or more	One every year (12 months)

Well Woman Examinations. Services and supplies provided by an OB/GYN specialist for a gynecological exam in connection with a routine test to detect cervical cancer (*i.e.*, pap smear). You will not have to pay an office co-payment for well woman examinations provided by a Participating Provider.

Routine Mammograms are provided for at 100% as follows:

1. one baseline mammogram from age 35 to 40;
2. one mammogram every two years from age 40 to 49.
3. one mammogram every year from age 50 and thereafter.

Note. An annual mammography can be received if Medically Necessary, based on the patient's family history.

Adult Immunization. Immunizations, including voluntary immunizations given as standard medical practice for adults when provided by a Participating Provider. You will not have to pay an office co-payment for adult immunization when provided by a Participating Provider.

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

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

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

Physical Therapy, Physical Medicine and Occupational Therapy – The following services provided by a Physician under a treatment plan which offers a reasonable expectation of significant improvement:

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

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

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

For Outpatient Occupational Therapy only, our maximum payment is limited to 24 visits per Year. Additional visits are payable if Medically Necessary and if prior authorization is obtained, and are limited to **\$25** for each authorized additional visit.

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

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

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

Items a through d above are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment"). Item e above is covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

2. Diabetes education program which:
 - a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.
 - d. Is subject to a calendar year benefit maximum of \$100 per person.

Diabetes education services are covered under Plan benefits for professional services by *physicians*.

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

These items must be obtained either from a retail *pharmacy* or through the mail service program (see YOUR PRESCRIPTION DRUG BENEFITS on page 29).

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

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

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.
5. Anthem Blue Cross Life and Health must pre-authorize participation once all of the above conditions are met.

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

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

Routine patient care costs do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

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

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreement regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in GRIEVANCE PROCEDURES.

Contraceptives. Services and supplies in connection to contraception when provided with the following:

- Injectable drugs and implants for birth control, administered in a *physician's* office.
- Intrauterine contraceptive devices (IUD) and diaphragms, dispensed by a *physician*.
- Professional services of a physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms (subject to calendar year deductible).

Contraceptive coverage will be provided for prescription contraceptive drugs that are approved by the Food and Drug Administration (FDA) and prescribed by your *physician*, unless your physician determines that the above contraceptive methods are not appropriate for you based on your medical or personal history.

GENERAL EXCLUSIONS AND LIMITATIONS

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

Not Medically Necessary – Services or supplies that are not Medically Necessary, as defined.

Experimental or Investigative – Any Experimental or Investigative procedure or medication.

Crime or Nuclear Energy – Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered – Services received before your Effective Date or during an inpatient Stay that began on or before your Effective Date. Services received after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Excess Amounts. Any amounts in excess of Covered Expense or the Lifetime Maximum.

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

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

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

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

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

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

Not Specifically Listed – Services not specifically listed in this Plan as covered services.

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

Mental or Nervous Disorders – Learning disabilities, behavior problems, mental retardation or autistic disease of childhood, except as specifically stated in “Attention Deficit Disorders” provision of MEDICAL CARE THAT IS COVERED.. Mental or Nervous Disorders or substance abuse, except services and supplies for detoxification.

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

Orthodontia – Braces and other orthodontic appliances or services.

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

Hearing Aids or Tests – Hearing aids. Routine hearing tests, except as specifically provided under YOUR PREVENTIVE CARE BENEFITS.

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

Outpatient Occupational Therapy – Outpatient occupational therapy, except as stated in the “Outpatient Occupation Therapy” provision of the MEDICAL CARE THAT IS COVERED.

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

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

Obesity – Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity, as determined by us, if we authorize the treatment in advance as Medically Necessary and appropriate.

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

Sterilization Reversal – Reversal of sterilization.

Infertility Treatment – Any services or supplies furnished in connection with the diagnosis and treatment of Infertility, including, but not limited to, diagnostic tests, medications (i.e. Clomid, Pergonal, Metrodin), surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Orthopedic Supplies – Orthopedic shoes (except when joined to braces) or shoe inserts.

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

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

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

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

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

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

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

Routine Exams or Tests – Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Routine Physical Exam," "Well Baby and Well Child Care", "Well Woman Examinations", "Routine Mammograms" or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, health or beauty aids.

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

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

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

PRE-EXISTING CONDITION EXCLUSION

New subscribers and their dependents who are enrolled within 31 days of becoming eligible for coverage will not have any pre-existing coverage limitations. No payment will be made for services or supplies for the treatment of a Pre-Existing Condition during a period of six months following the enrollment of a subscriber or their eligible dependents who enroll after their initial 31 days of eligibility. However if you were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The *pre-existing condition* exclusion does not apply to pregnancy nor to a child who is enrolled in the *plan* within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior *creditable coverage*. Most prior health coverage is *creditable coverage* and can be used to reduce the *pre-existing condition* exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the six-month exclusion period by your *creditable coverage*, you should give us a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have *creditable coverage*. Please contact us if you need help demonstrating *creditable coverage*. All questions about the *pre-existing condition* exclusion and *creditable coverage* should be directed to the customer service telephone number listed on your identification card.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

MCSIG PLAN ELIGIBILITY

WHEN BENEFITS BEGIN

1. You are eligible under the Plan if you are a subscriber as defined in the Definitions Section. You must enroll within 31 days from the date you are eligible for benefits as determined by your School District.
2. Your lawful Spouse of the opposite sex as defined in the Definitions Section is eligible for coverage on the first of the month following enrollment if all paperwork is complete and if:
 - An enrollment form has been submitted by you, and
 - A certified copy of your marriage certificate is submitted by you, and
 - The spouse affidavit of coverage form has been submitted and evidences that:
 - The spouse is unemployed, self-employed, or retired; or
 - The spouse is employed and the spouse's employer does not offer medical insurance coverage for the spouse; or
 - The spouse is employed and the spouse's employer does offer medical insurance coverage for the spouse but the spouse does not meet the employer's medical insurance eligibility requirements, or
 - The spouse is employed and the spouse's employer does offer medical insurance coverage for the spouse but the employer pays less than 75% of the employee-only premium, or
 - The spouse is employed and the employer pays at least 75% of the employee-only medical premium through any source (such as direct payment or through a Section 125 benefits plan) and the spouse is currently enrolled in their employer's medical insurance coverage.
- 2a. Your lawful dependents as defined in the Definitions Section are eligible for coverage at the same time as you if:
 - An enrollment form has been submitted by you, and
 - A certified copy of the dependent's birth certificate or other documentation evidencing qualifying relationship to the MCSIG participant is submitted by you (e.g., adoption or guardianship papers, marriage certificate establishing step-parentage, etc). In some cases multiple documents may be required.

3. Your new spouse is eligible for coverage on the first day the month following the date of your marriage if a Change Form has been submitted by you within 31 days of the date of your marriage. (A certified copy of the Marriage License or Certificate is required.)
4. Your Domestic Partner is eligible for coverage on the first of the month following enrollment if all paperwork is complete and if:
 - An enrollment form has been submitted by you, and
 - A copy of the recorded Declaration of Domestic Partnership filed with the State of California has been submitted by you, and
 - The domestic partner affidavit if coverage form has been submitted and evidences that:
 - The domestic partner is unemployed or self-employed, or retired; or
 - The domestic partner is employed and the domestic partner's employer does not offer medical insurance coverage for the domestic partner; or
 - The domestic partner is employed and the domestic partner's employer does offer medical insurance coverage for the domestic partner but the domestic partner does not meet the employer's medical insurance eligibility requirements, or
 - The domestic partner is employed and the domestic partner's employer does offer medical insurance coverage for the domestic partner but the employer pays less than 75% of the employee-only premium, or
 - The domestic partner is employed and the employer pays at least 75% of the employee-only medical premium through any source (such as direct payment or through a Section 125 benefits plan) and the domestic partner is currently enrolled in their employer's medical insurance coverage.

In order for the subscriber to include their domestic partner as a family member, the subscriber and domestic partner must meet the following requirements:

- a. Must register with Secretary of State. You must complete the "Declaration of Domestic Partnership" (DPA 680) form and submit to Secretary of State.
- b. Must be same sex over 18 and opposite sex over age 62. If you and your domestic partner are of the same sex, or if you and your domestic

partner are opposite sexes and one partner is at least 62 years old, then you may be eligible to register a domestic partnership with the Secretary of State. You may register by completing an application, having both partners' signatures notarized, and submitting it to the Secretary of State's office with the appropriate fee.

- c. Return copy of your "filed" Declaration of Domestic Partnership. You will then be given an enrollment form to add your Domestic Partner. A MCSIG white three-part change form will not be accepted.
 - d. You may enroll children of your domestic partner, if the children meet the other criteria for coverage (i.e, under age 25, full-time student, unmarried, not in military, not covered in the Health Program in their own right through qualifying employment.) All MCSIG guidelines will apply.
5. Your newborn infant is covered for the first thirty-one days of life for illness and injury, provided that Subscriber or Dependent Spouse is covered at the time of the birth. Coverage after 31 days is contingent upon the Subscriber submitting a Change Form within 31 days following the child's birth. (A copy of the Birth Certificate is required.)
6. You, your Spouse's or your Domestic Partner's newly-adopted Children or Children placed for adoption will be covered from the date on which either:
- a. the adoptive Child's birth parent, or other appropriate legal authority, signs a written document granting the Subscriber or Spouse the right to control the health care of the Child (in the absence of a written document, other evidence of the Subscriber's or Spouse's right to control the health care of the Child may be used); or
 - b. the Subscriber or Spouse assumed a legal obligation for full or partial financial responsibility for the Child in anticipation of the Child's adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.
7. A child for whom the Subscriber, Spouse, or Domestic Partner has been appointed legal guardian by a court of law. You must meet the following guidelines:
- a. The guardian must have sole, court approved legal guardianship for a minimum of one year prior to the coverage effective date. Child must reside with the guardian, with the exception of an under 18 year old, full time college student.

- b. The guardian's dependent must be under 18 years of age and related to the covered subscriber or their covered spouse or domestic partner as follows:
 - Grandchildren, brother, sister, nephew, step-grandchild, step-children, children of deceased former spouse (ex-step children) or as otherwise determined by the MCSIG Board.
- c. The guardian's dependent must be enrolled in a medical plan in order to enroll in a dental or vision plan.
- d. The guardian must show evidence of sole, court approved legal guardianship and evidence of relation, such as birth certificates, to the MCSIG eligibility department and verifiable to MCSIG'S satisfaction.
- e. Evidence of insurability is required. An evidence of insurability application must be completed and signed by the legal guardian and coverage may commence only after review and approval of the application by underwriting.
- f. If a dependent is enrolled under the guardianship guidelines and their coverage is dropped, they may not be re-enrolled for two years, and the same requirements above will apply, unless otherwise determined by the MCSIG Board.
- g. The guardian must re-certify their evidence of sole, court appointed legal guardianship every two year in order to continue coverage for guardianship.
- h. If, at any time, the dependent of the guardian is eligible for other medical, dental or vision group coverage, the dependent must be enrolled in such coverage and MCSIG'S coverage will be secondary.

If a subscriber submits an Enrollment Form/Change Form for themselves, their spouse, or their child outside the time limits as specified in this section, coverage will begin on the first day of the month following the date of submission if certificate of coverage is provided. The Member must have been covered under another plan within the last 63 days, otherwise, he/she will have to wait until the reenrollment.

Changing Plans

An annual re-enrollment will be held each November. At that time, if your district allows, you can change your plan of coverage and the new plan will become effective the following January 1. To request a change in Plan, you must submit a completed Change Form to your School District's benefits department during November.

Throughout the year, moving upward to a different Plan of benefits will be allowed for the following events only:

1. change in marital status;
2. change in dependent's status;
3. loss or acquisition of other group insurance coverage; or
4. change in employment status that changes your eligibility for benefits or source of payment.

A Change Form must be submitted within 31 days from the occurrence of any one of the above events.

Change or Discontinuance of Benefits

MCSIG may at any time change or discontinue the benefits provided by the Plan, but, no change or discontinue may effect in any way the amount or terms of any benefits payment under the Plan prior to the date of such change or discontinuance.

Reinstatement of Benefits

If a subscriber voluntarily chooses to disenroll their dependent(s) (the eligible subscriber must be covered) from coverage under this plan, they must wait until the next re-enrollment period to be reinstated.

If reinstatement is related to a Leave of Absence, contact your School District's benefit department.

TERMINATION OF BENEFITS

Subscriber

Coverage under the Plan terminates on the earliest of the following dates:

1. on the date the Plan terminates;
2. on the last day of the month in which you fail to meet the eligibility requirements established by the Plan; or
3. on the last day of the month for which the last contribution is made, if you are required to contribute and fail to make the required contribution when due.

Dependents

Coverage under the Plan terminates on the earliest of the following dates:

1. on the date the Plan terminates dependent coverage;
2. on the last day of the month in which your eligibility terminates;
3. on the last day of the month for which the last contribution is made, if you are required to contribute and fail to make the required contribution when due.
4. on the last day of the month upon entry of a final decree of divorce, annulment, or dissolution of marriage (if the Subscriber contributes toward the cost of Dependent coverage, termination may occur earlier);
5. on the last day of the month upon attainment of the age limits specified in the definition of "Dependent;" or
6. on the last day of the month in which your Dependent ceases to meet the definition of "Dependent."
7. with respect to a surviving Spouse and Dependent Children who continue to be eligible after your death, provisions 5, and 6, above apply, in addition to the following termination provisions:
 - on the last day of the month in which the Spouse or Child becomes eligible for coverage under another group health plan;
 - on the last day of the month in which the Spouse remarries; or
 - on the last day of the month for which the last contribution is made if the Spouse or Child fail to make the required contribution when due.

Note. It is your responsibility to notify MCSIG to cancel your domestic partner's coverage if you terminate your relationship or cease to share a common residence. Failure to notify MCSIG of termination, you will be held responsible for all costs for medical services received by your partner after the termination of your relationship.

Unfair Termination of Coverage

Your coverage may not be terminated because of your health status or requirements for health care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the MCSIG Appeals Committee.

CONTINUATION OF GROUP COVERAGE

In accordance with The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may be entitled to continuation of coverage. Check with your District for details.

DEFINITIONS

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

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

Qualified Member means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this Agreement as either a subscriber or Dependent; and (b) a Child who is born to or placed for adoption with the Subscriber during the COBRA continuation period. Qualified Member does not include any person who was not enrolled during the Initial Enrollment Period, including any Dependents acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above. It does not include domestic partners if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. For Subscriber and Dependents:

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

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

- a. The Agreement expressly includes coverage for retirees; and
- b. Such cancellation or reduction of benefits occurs within one year before or after MCSIG's filing for bankruptcy.

3. **For Dependents:**

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

ELIGIBILITY FOR COBRA CONTINUATION

A subscriber or Dependent may choose to continue coverage under the Agreement if his or her coverage would otherwise end.

Exceptions: A Member is not entitled to continue coverage if, at the time of the Qualifying Event, that Member is: (1) entitled to Medicare*; or (2) covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Member. If one Member is unable to continue coverage for these reasons, other entitled Members may still choose to continue their coverage.

*Entitlement to Medicare will not preclude a person from continuing coverage for which the person became eligible due to Qualifying Event 2.

TERMS OF COBRA CONTINUATION

Notice. Your School District, MCSIG or its administrator (we are not the administrator) will notify either the Subscriber or Dependent of the right to continue coverage under COBRA, as provided below:

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

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

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

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by MCSIG within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A spouse or Child acquired during the COBRA continuation period is eligible to be enrolled as a Dependent. The standard enrollment provisions of the Agreement apply to enrollees during the COBRA continuation period.

Cost of Coverage. The School District or MCSIG requires that you pay the entire cost of your COBRA continuation coverage. This cost, called the "subscription charge", must be remitted to the School District or MCSIG each month during the COBRA continuation period. We must receive payment of the subscription charge each month from MCSIG in order to maintain the coverage in force.

Besides applying to the Subscriber, the Subscriber's rate also applies to:

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

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

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

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

For Dependents properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the Agreement.

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the Subscriber, divorce or legal separation, or the end of dependent Child status;*
3. The end of 36 months from the date the Subscriber became entitled to Medicare, if the Qualifying Event was the Subscriber's entitlement to Medicare;
4. The date the Agreement terminates;
5. The end of the period for which subscription charges are last paid;
6. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Member, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date the Member becomes entitled to Medicare.

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

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

If your COBRA continuation under this Plan ends in accordance with items 1 or 2, you are eligible for medical conversion coverage. The School District or MCSIG will provide notice of this conversion right within 180 days prior to such termination date.

If continuation coverage ends due to items 2 or 7 above, the surviving spouse of a subscriber or of a retired Employee is eligible for the coverage specified in this Plan under COVERAGE FOR SURVIVING SPOUSES OF EMPLOYEES.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

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

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

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The School District or MCSIG requires that you pay the entire cost of the extended continuation coverage.
3. We must receive timely payment of the subscription charge each month in order to maintain the extended continuation coverage in force.

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;
3. The date the Agreement terminates;
4. The end of the period for which subscription charges are last paid;
5. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Member, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date the Member becomes entitled to Medicare.

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

CONTINUATION FOR DISABLED DISTRICT EMPLOYEES

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 employee, your benefits under this Plan may be continued.

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

Cost of Coverage. The School District or MCSIG requires that you pay the entire cost of your continuation coverage. This cost (called the "subscription charge") must be remitted to MCSIG each month during your continuation. We must receive payment of the subscription charge each month in order to maintain the coverage in force. We will accept subscription charges only from MCSIG. Payment made by you directly to us will not continue coverage.

When Continuation Coverage Begins. When continuation coverage is elected and the subscription charge 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 this Plan.

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

1. The date this Plan terminates;
2. The end of the period for which subscription charges are last paid; or
3. The date the maximum benefits of this Plan are paid.

For Dependents, this continuation coverage ends according to the provisions of the section entitled HOW COVERAGE BEGINS AND ENDS.

SURVIVOR BENEFITS

If a subscriber dies while covered under the Plan, the surviving Spouse or Children who are covered under the Plan at the time of the Subscriber's death are entitled to enroll in the Plan in accordance with the following provisions:

- surviving Spouse or Children must enroll within 31 days of the date of the Subscriber's death;
- contributions for survivor benefits are the responsibility of the surviving Spouse or Children;
- coverage for survivor benefits terminates as enumerated in the Termination of Benefits section, item 7; and
- this provision is in lieu of the COBRA continuation benefit option.

UNPAID LEAVE OF ABSENCE PROVISION

Please contact your School District office for the details of this provision.

EXTENSION OF BENEFITS

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

1. If you are confined as an inpatient in a Hospital or Skilled Nursing Facility, you are considered totally disabled as long as the inpatient *stay* is Medically Necessary, and no written certification of the total disability is required. If you are discharged from the Hospital or Skilled Nursing Facility, you may continue your total disability benefits by submitting written certification by your Physician of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.
2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your Physician of the total disability. We must receive this certification within 90 days of the date coverage ends under this Plan. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
 - a. You are no longer totally disabled.
 - b. The maximum benefits available to you under this Plan are paid.
 - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
 - d. At the end of the Year following the Year in which you become disabled.

CONVERSION

To apply for a conversion plan, you must submit to the Claims Administrator (please call: 800-333-0912) an application and make the first premium charge payment within 63 days of the date your coverage under the employer's *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the plan terminates and is replaced by another group plan within 15 days.
2. You are not eligible if your coverage under this *plan* ends because premium charges are not paid when due because you (or the subscriber who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

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

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

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

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when by law its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

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

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

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

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan. When This Plan is the Principal Plan, MCSIG PPO Plans will NOT coordinate benefits with This Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense. Note: If This Plan is not the Principal Plan, then This Plan will only coordinate benefits with other like/EPO type plans and only for in-network providers as defined by This Plan.

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as a subscriber pays before a plan which covers you as a dependent. But, if you are a Medicare member and also a dependent of a subscriber with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as a subscriber.
3. For a dependent Child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

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

- a. If the parent with custody of that Child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
- b. If the parent with custody of that Child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that Child as a dependent of the parent with custody.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Dependents. Any Member who is a subscriber or a Dependent of a subscriber, and eligible for Medicare, will receive the full benefits of this Plan, except for the following:

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

In cases where exceptions 1 or 2 apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

For Retired Employees and Their Spouses. If you are a *retired employee* or the *spouse* of a *retired employee* and you are eligible for Medicare Part A, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below. Failure to enroll in Medicare Part B and a MCSIG’s retiree plan will result in termination of MCSIG’s plan coverage.

Coordinating Benefits With Medicare. The *plan* will not provide benefits that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this *plan* except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.
2. For services you receive that are covered both by Medicare and under this *plan*, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not exceed *covered expense* for the covered services.

We will apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any.

GENERAL PROVISIONS

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

Independent Contractors. Our relationship with providers is that of an independent contractor. Physicians, and other health care professionals, Hospitals, Skilled Nursing Facilities and other community agencies are not our agents nor are we, or any of our subscribers, a subscriber or agent of any Hospital, medical group or medical care provider of any type.

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

Terms of Coverage

1. In order for you to be entitled to benefits under the Agreement, both the Agreement and your coverage under the Agreement must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The Agreement is subject to amendment, modification or termination according to the provisions of the Agreement without your consent or concurrence.

Protection of Coverage. We do not have the right to cancel your coverage under this Plan while: (1) this Plan is in effect; (2) you are eligible; and (3) your subscription charges are paid according to the terms of the Agreement.

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

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

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

Medical Necessity. The benefits of this Plan are provided only for services which we determine to be Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this Plan is available to you upon request.

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

Benefits Not Transferable. Only the Member is entitled to receive benefits under this Plan. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 9 months to equal a total of 12 months will be allowed. We are not liable for the benefits of the Agreement if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. We will pay the benefits of this Plan directly to contracting hospitals, participating providers, CME and medical transportation providers. Also, we will pay Non-Contracting Hospitals and other providers of service directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this Plan to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this Plan, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator - COBRA and ERISA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the School District or MCSIG or to a person or entity other than us, engaged by the School District or MCSIG to perform or assist in performing administrative tasks in connection with this health plan. The School District or MCSIG is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the School District or MCSIG is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your Dependents. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any Participating Provider or Other Health Care

Provider any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You will be liable, however, to pay Non-participating Providers any and all amounts billed.

Renewal Provisions. Your employer's health plan Agreement with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the Plan from time to time.

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

Transition Assistance for New *Beneficiaries*: Transition Assistance is a process that allows for completion of covered services for new *beneficiaries* receiving services from a *non-participating provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this *plan*.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls in this *plan*.
6. Performance of a surgery or other procedure that the *claims administrator* have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this *plan*.

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

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* are negotiated on a case-by-case basis. We will request that the *non-participating provider* agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the *non-participating provider* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *physician* review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with the *claims administrator* terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

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

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

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

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

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

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider's services will not be continued. If you disagree with the determination regarding continuity of care, you may file complaint as described in the COMPLAINT NOTICE.

CLAIM APPEAL PROCESS

If there are questions about a claim denial, the member should contact MCSIG for an explanation or reconsideration. If results are unsatisfactory after this reconsideration, the member may appeal the matter to the Claims Appeal Committee.

If the member is not satisfied with the Committee's decision, the member may appeal the decision through arbitration if the amount exceeds the jurisdictional limits of the small claims court, or file any other legal action.

BINDING ARBITRATION

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

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

The *member* 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 *member* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *member* 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 *member*.

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*. 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 *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the member and the *plan administrator*.

HEALTH PROMOTION PROGRAM

- *“Take Time for Wellness”*
- Wellness is a choice - a decision you make to move toward optimal health.

BACKGROUND:

The health promotion program began in October of 1994, as the result of a growing awareness among subscribers and management that many illnesses and disabilities could be prevented through early detection and education.

MISSION STATEMENT:

“The mission of the program is to promote and preserve the health of all subscribers through a comprehensive health promotion program. It is our unswerving belief that each person can enhance the quality of his or her life through a continual process of lifestyle improvement and balanced living.”

PURPOSE:

The purpose of the program is to provide a combination of educational, organizational, and environmental activities to encourage subscribers to adopt healthier lifestyles and become better consumers of health care services.

GOALS:

- Prevent diseases through education, early detection and treatment
- Improve morale and productivity
- Reduce absenteeism
- Reduce subscriber turnover and replacement costs
- Contain health care costs

PROFESSIONAL STAFF:

The program is under the direction of the Health and Wellness Program Manager. The Manager’s chief responsibilities are to design and coordinate wellness programs that protect our member districts’ most valuable assets - its subscribers and their families.

HEALTH PROMOTION SERVICES:

- An Employee Wellness Committee
- Flu Shots
- Health Screenings (blood pressure and cholesterol, etc.)
- Health Risk Appraisals
- Wellness Employee of the Quarter Recognition
- Health Fairs
- Quarterly Newsletter *Wellness Works!*
- Healthy Lifestyle Solutions Incentive Program
- Health Education Class Rebates (Smoking Cessation, Stress Management, Yoga, Tai Chi, etc.)
- Healthy Weight Incentive Program
- Gym Membership Discounts
- Special Events (Exercise of Challenge, 10K-a-day, etc.)
- Educational Resources (Wellness Lending Library, Speakers Bureau, Pamphlets)
- Worksite Environmental Support
- School District Wellness Ambassadors/School Site Wellness Coordinators

Who is eligible?

All subscribers, retirees and dependents enrolled in any of the MCSIG medical plans are eligible.

How do I find out what is offered?

The quarterly wellness newsletter, *Wellness Works!*, will list classes and upcoming activities. In addition, you may contact your Wellness Committee district representative or the Health and Wellness Program Manager for further information.

Will the program cost me anything?

The program is currently offered at low or no cost to all MCSIG members.

How do I start?

Interested subscribers may register for activities at your school site or by calling the Health Promotion Manager at (831) 755-0161. Start today and practice what may be the most effective medicine of all - the preventive kind.

Health Promotion...helping people stay healthy.