County of Sonoma Health Plan (CHP)

Plan Document describing the CHP-Exclusive Provider Organization (EPO) Medical Plan and CHP-Preferred Provider Organization (PPO) Medical Plan for Employees and Retirees

Amended, restated and effective January 1, 2020

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Dear Plan Participants:

This is the Plan Document for the self-funded medical plan benefits of the **County of Sonoma Health Plan (CHP)** ("Plan). This document describes the County's Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) Medical plans including outpatient prescription drug benefits. These Plan benefits are designed to help cover many of your expenses when you become sick or are injured. Plus, the medical **plans also provide an array of preventive/wellness services** to help you maintain your current good health and to identify health risk factors that can, if not corrected, eventually lead to chronic diseases.

The County of Sonoma EPO and PPO Medical Plan has been adopted for the exclusive benefit of Employees and Retirees and their Covered Dependents.

Here are some important tips on using your Medical Plan benefits:

- ✓ Both the CHP EPO and CHP PPO Medical Plans give you access to a network of Participating Providers who give you a discount off their usual cost of services. **Using Participating Providers will result in a substantial savings to you and to the Plan.**
- ✓ Because EPO and PPO Participating Providers (also called in-network providers) are added to or removed from the network each month, **check with a provider to see if they are still participating as an in-network provider before you schedule an appointment or go get lab work or x-rays**.
- ✓ **Certain services require pre-approval** (also called precertification or prior authorization) before the service is performed. This includes certain medical plan services and certain outpatient prescription drugs and is discussed in the Utilization Management chapter.
- ✓ Notify the County of Sonoma Human Resources Benefits Unit of any **address changes** to ensure that you receive updated Plan and COBRA election information. Inform the County of Sonoma Human Resources Benefit Unit of **any changes in the status of your Eligible Dependents** (for example, marriage, divorce, child reaches the age of 26 years).
- ✓ Important and helpful contact information is listed on the **Quick Reference Chart** located in the front of this document.

As your plan administrator, the County makes every effort to administer the Plan carefully, making changes to your Plan as the Plan's financial condition changes and as mandated by law. Eligibility provisions may be modified in accordance with law, and benefits may be increased or decreased from time to time. You will be notified if there are material plan changes.

Sincerely,

County of Sonoma Human Resources Benefits Unit

INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Plan Document describes the self-funded EPO and PPO Medical Plan options of the County of Sonoma Health Plan for eligible employees, retirees, and their enrolled dependents. The Plan described in this document is effective January 1, 2020, and replaces all other plan documents, summary plan descriptions, and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility chapter in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status, satisfactory to the Plan. If you have declined any of the coverages described in this document, the chapters pertaining to those declined coverages do not apply to you.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

This document will help you understand and use the benefits offered by the County of Sonoma Health Plan. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions chapters.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

IMPORTANT INFORMATION
The County of Sonoma is committed to maintaining health care coverage for employees, retirees, and their families at an affordable cost, however, because future conditions cannot be predicted, the County's Plan Administrator reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the material changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is not established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

The PPO and EPO medical plan options are self-funded, meaning the contributions from the County of Sonoma, and enrolled employees and retirees are used to pay plan benefits, including benefits for services provided to Plan participants and claims administration. Independent Claims Administrators pay benefits out of general County assets. The insured health plan options including the Health Reimbursement Arrangement (HRA), Flexible Spending Accounts (FSA), Medical Health Maintenance Organization (HMO), Deductible HMO, and High Deductible Health Plan (HDHP) plans, dental plan, vision plan, and life insurance benefits are not described in this document. Contact the County's Human Resources Benefits Unit for more information.

SUGGESTIONS FOR USING THIS DOCUMENT

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the **Definitions** chapter. The **Table of Contents** provides you with an outline of the chapters. The **Definitions** chapter explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses and phone numbers of the key contacts for your benefits such as the Medical Plan Claims Administrator, Prescription Drug Program or Medical Networks.
- The **Eligibility chapter** outlines who is eligible for coverage and when coverage ends while the **COBRA chapter** discusses your options if coverage ends for you or a covered Spouse or Dependent Child.

- Review the **Medical Expense, Schedule of Medical Benefits and Medical Exclusions chapters.** These describe your EPO Plan and PPO plan benefits in more detail. There are examples, charts and tables to help clarify key provisions and more technical details of the coverages.
- Review the **Medical Networks and Utilization Management chapters**. They describe how you can maximize plan benefits by following the provisions explained in these chapters.
- Refer to the **General Provisions chapter** for information regarding your rights, while the **Claim Filing and Appeal Information chapter** tells you what you must do to file a claim and how to seek a review (appeal) if you are dissatisfied with a claims decision.
- The chapter on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from any other source.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the County's Human Resources Benefits Unit information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in Domestic Partnership status, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan via the County's Human Resources Benefits Unit within 31 days, after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may:

a. cause you, your Spouse, Domestic Partner, and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person.

LANGUAGE ASSISTANCE

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Human Resources at 707-565-2900.

The Medical Plan Claims Administrator has a **Language Assistance Program** to provide certain written translation and oral interpretation services to California members with limited English proficiency. The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you.

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages: Spanish, Chinese, Vietnamese, Korean, or Tagalog. Oral interpretation services are available in additional languages.

To request a written or oral translation, please contact the Member Services phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. See also the Medical Plan Claims Administrator's contact information on the Quick Reference Chart in this document.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the County Human Resources Benefits Unit at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, their staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Plan Administrator and obtain a written response from the Plan Administrator. Contact information for the Plan Administrator is listed on the Quick Reference Chart.

In the event of any discrepancy between any information that you receive from the staff of the County Human Resources Benefits Unit, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

<table>
<tr><th colspan="2">QUICK REFERENCE CHART</th></tr>
<tr><th>Information Needed</th><th>Whom to Contact</th></tr>
<tr><td>Claims Administrator for the Medical Plans
• Claim Forms (Medical)
• Medical Claims Administration
• Medical Plan Claim Appeals
• Eligibility for Coverage
• Plan Benefit Information
• Help understanding the covered wellness/preventive benefits payable by the Medical Plan

The covered medical plan benefits described in this document are funded by the County of Sonoma 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).

In addition to Anthem's assistance, you can visit these websites below for information on Wellness/Preventive Benefits (including immunizations) payable by the Medical Plan in accordance with Health Reform regulations:
• https://www.healthcare.gov/coverage/preventive-care-benefits/ with more details at:
• https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations
• https://www.hrsa.gov/womens-guidelines/index.html /
• http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001</td><td>Anthem Blue Cross Life and Health (also referred to as Anthem)
Member Service: (800) 759-3030

For Language Assistance Program, contact Member Services.

Address for submission of a claim appeal:
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 4310, Woodland Hills, CA 91365-4310
Anthem Blue Cross Website: www.anthem.com/ca
• Information specific to your benefits and claims history are available by calling the toll free number on your identification card.
• You may use Anthem Blue Cross's web site to access benefit information, claims payment status, benefit maximum status, participating providers, or to order an ID card. Simply log on to https://www.anthem.com/ca/ select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure Member Access Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the Member Access Web site. Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross.

Group Numbers:
• CHP EPO Plan: Group # 175130M100 (CA)
CVS/Caremark Group #: 3439-1004
• CHP PPO Plan: Group # 175130M051 (CA)
CVS/Caremark Group #: 3439-1002</td></tr>
</table>

QUICK REFERENCE CHART

<table>
<tr><th>Information Needed</th><th>Whom to Contact</th></tr>
<tr><td>Utilization Review (UR) Program
(UR Company)
• Precertification of Admissions and certain Medical Plan Services
• List of designated Centers of Medical Excellence (COME) facilities
• Health Plan Individual Case Management
• Appeal of Utilization Review decisions</td><td>Anthem Blue Cross Life and Health
Member Services: (800) 759-3030
Website: www.anthem.com/ca/</td></tr>
<tr><td>Medical Plan Network
(if you reside <u>within</u> the state of California)
• Medical Network Participating Provider Directory for the <u>Prudent Buyer PPO Plan</u>
• Additions/Deletions of Network Providers
• (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)</td><td>Anthem Blue Cross Life and Health
Member Services: (800) 759-3030
Website for Network Provider Directory: www.anthem.com/ca
On the website, click on “Find a Doctor” when selecting a provider search. If you do not have Internet access, contact Anthem’s Member Services telephone above.
For medical services rendered in California by non-participating providers send claims to:
ANTHEM BLUE CROSS LIFE AND HEALTH
P.O. Box 60007
Los Angeles, CA 90060-0007
CAUTION:
• For the PPO plan, use of a non-network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider’s billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan’s payment for a covered service.
Your lowest out of pocket costs will occur when you use In-Network providers.
• For the EPO plan, all care must be provided, or coordinated by, a participating provider physician. Benefits for non-participating providers are provided under the Plan only if you have an authorized referral, for an emergency or for urgent care.</td></tr>
</table>

QUICK REFERENCE CHART

<table>
<tr><th>Information Needed</th><th>Whom to Contact</th></tr>
<tr><td>Medical Plan Network
(if you reside <u>outside</u> the state of California)
• Medical Network Provider Directory
• Additions/Deletions of Network Providers
• (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)

CAUTION:
• For the PPO plan, use of a non-network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service.
Your lowest out-of-pocket costs will occur when you use In-Network providers.
• For the EPO plan, all care must be provided, or coordinated by, a participating provider physician. Benefits for non-participating providers are provided under the Plan only if you have an authorized referral, for an emergency or for urgent care.</td><td>BlueCard Network Providers from Anthem Blue Cross Life and Health
Member Services: (800) 759-3030
The BlueCross BlueShield Global Core Service Center is available
24 hours a day, 7 days a week toll-free at 800-810-BLUE (2583) or by calling collect at 804-673-1177.

To find a BlueCard provider outside of California please contact Anthem's Member Services telephone above.</td></tr>
<tr><td>Outpatient Prescription Drug Program
administered by a Prescription Benefit Manager (PBM)
• ID Cards
• Retail Network Pharmacies
• Mail Order (Home Delivery) Pharmacy
• Prescription Drug Information
• Formulary of Preferred Drugs
• Precertification of Certain Drugs
• Direct Member Reimbursement (for Non-Network retail pharmacy use)</td><td>CVS Caremark
Customer Service: (800) 966-5772
Telephone for Precertification of Drugs: (855) 240-0536
Retail Pharmacy Location Directory website: www.caremark.com

Specialty Drugs: (800) 237-2767
Specialty Drugs website: https://www.cvsspecialty.com/wps/portal/specialty

Mail order address:
P.O. Box 659541, San Antonio, TX 78265-9541

Direct Member Reimbursement for Non-Network Retail Claims:
CVS CAREMARK
P.O. Box 52116
Phoenix, AZ 85072</td></tr>
<tr><td>Employee Assistance Program (EAP) for all County employees
• Professional, confidential information, support, and referral to help individuals cope with personal problems that impact their home and work life.
• EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, grief, financial and legal problems.
• The EAP provides up to six (6) face-to-face (in person) sessions per problem. Additional mental health and substance abuse treatment services are available under your medical plan.</td><td>ValueOptions
Phone: (866) 484-4961 available 24/7
Website: http://www.valueoptionsofcalifornia.com/</td></tr>
</table>

QUICK REFERENCE CHART

Information Needed	Whom to Contact
COBRA Administrator • Information About Continuation Coverage • Dependents losing coverage eligibility • Cost of COBRA Continuation Coverage and COBRA Premium payments • Second Qualifying Event and Disability Notification	**P&A Administrative Services, Inc.** Phone:(800) 688-2611 Website: www.padmin.com
Benefits Administration • County's Employee Benefits Customer Service • **Employee Benefits Self-Service Portal** for benefit election changes and to update contact information • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC)	**County of Sonoma** **Human Resources Benefits Unit** 575 Administration Drive, Room 117 C Santa Rosa, CA 95403 Phone: **(707) 565-2900** Fax: (707) 565-3770 Email: benefits@sonoma-county.org Website: http://sonomacounty.ca.gov/hr/benefits/
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**County of Sonoma** **Compliance/Privacy Officer** 1450 Neotomas Ave., Suite 200 Santa Rosa, CA 95405 Phone: (707) 565-5703
Plan Administrator	**County of Sonoma Human Resources Benefits Unit** 575 Administration Drive, Room 117 C Santa Rosa, CA 95403 Phone: (707) 565-2900
County Wellness Program • Free Health Information	**Healthy Habits** Contact: (707) 565-2900 Website: http://sonomacounty.ca.gov/HR/Benefits/Healthy-Habits/
Healthcare Advocate The health advocacy program is a special benefit sponsored by the County that can help you understand and effectively navigate your health benefits. The advocates offer high touch and customized service and support for needs such as: • Choosing a health plan during Annual Enrollment • Benefits education and assistance for all types of health plans (medical, dental, etc.) • Getting the most of your healthcare dollars • Helping you find physicians and get care, obtain a second opinion • Troubleshooting medical claims/bills, coordinate grievances and appeals • Navigate Medicare (when you turn 65 and ongoing) • Access to a Health Library, educational webinars, and community education sessions • Connect you with expert healthcare resources	**Care Counsel - Healthcare Advocacy** Phone: (888) 227-3334 counselors available 8:30am to 5:00pm M-F Website: http://www.carecounsel.com/
Medical HMO and HDHP Plans	**Kaiser Permanente** Phone: (800) 464-4000 Website: www.my.kp.org/sonomacounty

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
	Sutter Health Plus Phone: (855) 315-5800 Website: www.sutterhealthplus.org/sonoma-county
	Western Health Advantage Phone: (888) 563-2250 Website: www.choosewha.com/sonoma-county
Dental Plan	**Delta Dental PPO** Phone: (800) 765-6003 Website: https://www.deltadentalins.com/
Vision Plan	**Vision Service Plan (VSP)** Phone: (800) 877-7195 Website: www.vsp.com
Life Insurance	**The Hartford** Phone: (888) 653-1124 Website: www.thehartford.com
Health Reimbursement Arrangement (HRA) Administrator (Active employees and Retirees) **and** **Flexible Spending Accounts (FSA) Administrator** (Active employees)	**P & A Group** Phone: (800) 688-2611 Website: www.padmin.com

ELIGIBILITY

HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

WHO IS ELIGIBLE FOR COVERAGE AND START OF COVERAGE

Employee Eligibility:

If you are an employee of the County of Sonoma scheduled to work 32 hours per pay period (.40 FTE) and working as a full-time permanent employee or a part-time permanent employee and meet the eligibility requirements as defined in your applicable Memorandum of Understanding (MOU), you are eligible for your own medical coverage.

Hour(s) of Service means, as determined by the County:

(1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for an employer; and

(2) each hour for which an employee is paid, or entitled to payment by an employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes "income from sources without the United States".

The County reserves the right to use a **Monthly Measurement Method** and/or a **Look Back Measurement Method** to determine if an employee reaches the level of a full-time employee, in accordance with IRS regulations under the Affordable Care Act. The Monthly Measurement Method identifies full-time employees based on the hours of service achieved for each calendar month. The Look-Back Measurement Method determines the status of a new employee or an ongoing employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the employee attained in a prior period (called a measurement period). The specific duration of periods under the Look Back Measurement Method are addressed in policies/procedures in the Human Resource Benefits Unit and can be changed on an annual basis as determined by the County.

For Employees who chose coverage under this Plan, coverage will become effective as of the first day of the month after you become benefits-eligible, but only if the Employee submits a completed written enrollment form that may be obtained from and returned to the County's Human Resources Benefits Unit and paid any required premium contribution for coverage.

Retiree Eligibility:

If you are a retired employee of the County, you are eligible for medical coverage if you:

a. Were eligible as an active employee before retirement; and
b. Are receiving retirement benefits from the Sonoma County's Employees Retirement Association (SCERA); and
c. Meet the specific eligibility requirements of the Memorandum of Understanding or Salary Resolution, which you were retired under as an active employee, or
d. Meet the eligibility requirements of an affiliated County agency, or
e. Meet the eligibility requirement pursuant to the Settlement Agreement in the lawsuit entitled Sonoma County Association of Retirees, et. al. v. Sonoma County, CV 09-4432 CW

For Retirees who chose coverage under this Plan, that coverage will become effective as of the first day of the month following or coinciding with the Retiree's retirement from the County, but only if the Retiree has submitted a completed written enrollment form that may be obtained from and returned to the County's Human Resources Benefits Unit and paid any required premium contribution for coverage.

If you or any of your eligible dependents turn age 65 and become Medicare eligible, it is required that you enroll in Medicare Parts A and B. In order to complete the enrollment process, retirees or any eligible dependents that turn age 65, must provide a copy of their Medicare card and complete new health enrollment forms. (Enrollment forms may be obtained from and are to be returned to the County's Human Resources Benefits Unit.) Proof of Medicare eligibility is required to maintain eligibility for coverage under this Plan. **Failure to enroll timely into Medicare and provide proof will result in termination of your health coverage under this Plan.**

Dependents' Eligibility:

If an Employee or Retiree elects coverage for themselves, they are also eligible to elect medical coverage for their Eligible Dependents on the later of the day the Employee or Retiree becomes eligible for their own medical coverage or the day the Employee or Retiree acquires an Eligible Dependent, either by marriage, birth, adoption, or placement for adoption, but only if:

- the Employee or Retiree has submitted a completed written enrollment form that may be obtained from and is to be returned to the County's Human Resources Benefits Unit; and
- if medical coverage is in effect for the Employee or Retiree on that day; and
- proof of Dependent status is submitted to the Plan with 31 days of the date of eligibility for coverage; and
- premium contributions required for coverage of the dependent are submitted to the Plan in a timely manner.

A Dependent may not be enrolled for coverage unless the Employee or Retiree is also enrolled.

Specific documentation to substantiate Dependent status may be required by the Plan. See the section called "Proof of Dependent Status" in this chapter.

Your Eligible Dependents include your lawful Spouse, registered Domestic Partner, and your Dependent Child(ren) as those terms are defined in the Definitions chapter of this document. Anyone who does not qualify as a Dependent Child or Spouse or Domestic Partner as those terms are defined by this Plan has no right to any coverage for Plan benefits or services under this Plan.

Domestic Partner:

Individuals who qualify as a Domestic Partner, as that term is defined in this Plan, may be eligible to enroll for coverage as a dependent of the employee or retiree upon obtaining a declaration of Domestic Partnership filed with the State of California, Secretary of State, as defined in California Family code section 297 et. seq. or (only if applicable to your bargaining unit) a County of Sonoma Affidavit of Domestic Partnership Benefits and submitting it to the County's Human Resources Benefits Unit. See the definition of Domestic Partner in the Definition chapter of this document.

- If the Domestic Partner and/or child of a Domestic Partner does not qualify as a tax dependent, where applicable state laws are involved, the employee will be taxed on the value of the benefits provided to him or her. This is called "imputed income" and the employee will have to pay tax on this amount.
- A Domestic Partner may enroll during Initial Enrollment or during the Open Enrollment period and coverage of the Domestic Partner will become effective the first of the month after meeting the Plan's proof of Domestic Partnership.
- Note that temporary continuation of coverage under a COBRA-like coverage is available to Domestic Partners and children of Domestic Partners.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status **will be required by the Plan**, and may include a birth certificate, marriage certificate, proof of the dependent's age, and the dependent's social security number. **Note that failure to provide timely proof of dependent status means that claims submitted to the Plan for the dependents will not be able to be considered for payment until such proof is provided.**

- **Marriage:** the certified marriage certificate.
- **Birth:** the certified birth certificate showing biological child of employee.
- **Stepchild:** the certified birth certificate, divorce decree and marriage certificate.
- **Adoption or placement for adoption**: Under this Plan, an adopted child means a child who is in the process of being adopted is considered a legally adopted child if the County receives legal evidence of both: (i) the intent to adopt; and (ii) that the employee, retiree, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the employee's, retiree's, spouse's or domestic partner's right to control the health care of the child.
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate.

- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and the child is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on the employee, retiree, spouse or Domestic Partner for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including proof that the child is claimed as a dependent for federal income tax purposes.

  The subscriber will be notified that their child's coverage will end (at least 90 days prior to the date the child reaches the plan's upper age limit).

  Initially, the Plan must receive the disability certification within 60 days of the date the subscriber receives the Plan's request. When a period of two years has passed, the County may request proof of continuing dependency and disability, but not more often than once each year. This proof of continuing disability will last until the child is no longer disabled or dependent on the employee, retiree, spouse or domestic partner for financial support.

- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.

See also the section on Failure to Provide Proof of Dependent Status under the Initial Enrollment section of this chapter.

An employee, or retiree must reimburse the Plan for any benefits that were paid for a Dependent at a time when that Dependent did not satisfy the definition of a Dependent or was not otherwise eligible for benefits under this Plan.

ENROLLMENT PROCEDURE

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special Enrollment, and Open Enrollment. These opportunities are described further in this chapter.

Procedure to request enrollment: Generally an individual must call, fax, e-mail or walk into the County's Human Resources Benefits Unit and indicate their desire to enroll in the Plan. (The contact information for the County's Human Resources Benefits Unit is listed on the Quick Reference Chart in the front of this document.) Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll at this time will be announced by the Plan at the beginning of the Open Enrollment period.

Once enrollment is requested, you will be provided with the steps to enroll that include all of the following:

a. submit a completed written enrollment form that may be obtained from the County's Human Resources Benefits Unit within 31 days of the date of eligibility for coverage, and
b. provide proof of Dependent status (as requested), and
c. pay any required premium contributions for coverage, and
d. perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, or Open Enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan. If enrollment has been requested within the required time limit but proper enrollment steps (including completion of paper enrollment documents) have not been completed, claims will not be able to be considered for payment until such enrollment has been completed and submitted to the County's Human Resources Benefits Unit.

A person who has not properly enrolled by completing the Plan's enrollment procedures (noted above) including requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Failure to Provide Proof of Dependent Status: See also the section on Proof of Dependent Status above. Claims for newly added dependents (e.g. Spouse, children, Domestic Partner) will not be considered for payment by this Plan until the County's Human Resources Benefits Unit receives verification/proof of dependent status.

DECLINING COVERAGE

Benefits eligible employees may pass up the opportunity to enroll in (decline/opt out of) medical, dental, and vision expense coverage under this Plan for yourself, but to do so, you must submit to the County's Human Resources Benefits Unit the completed portion of the enrollment form that pertains to declining coverage. Remember that a Dependent may not be enrolled for coverage unless the employee is also enrolled.

The opportunity to decline coverage is only available at one of the Plan's normal enrollment times: Initial, Special, or Open Enrollment. If, at a later date, you want the coverage you declined for yourself you may enroll only under the Special Enrollment provisions (when applicable and benefits-eligible) or the Open Enrollment provisions (when benefits-eligible) described later in this chapter. Enrollment forms may be obtained from the County's Human Resources Benefits Unit.

Note that **no additional compensation is paid** to you if you waive/decline benefit coverage.

INITIAL ENROLLMENT

An employee or retiree must enroll no later than 31 days after the date on which they are eligible for coverage by submitting a completed written enrollment form that may be obtained from the County's Human Resources Benefits Unit, providing proof of Dependent status (as appropriate) and paying any required contributions for coverage. If you want Dependent coverage, you must enroll your Eligible Dependents at the same time. See also the Enrollment Procedure section of this chapter for more information.

Start of Coverage Following Initial Enrollment:

1. For benefits-eligible employees, you become eligible for coverage on the first day of the month following employment in a benefits-eligible position. (This is your "waiting" period.) Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.
2. For benefits-eligible retirees, you become eligible for coverage on the first day of the month following or coinciding with retirement from the County. When dependent coverage is elected, coverage of an Eligible Spouse, Domestic Partner and/or Dependent Child(ren) begins on the date Retiree coverage begins.

See also the Special Enrollment provisions of this Plan described later in this chapter.

Failure to Enroll During Initial Enrollment (Very Important Information):

If, as an employee, you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period, unless you and/or your Eligible Dependent(s) qualify for the Special Enrollment described in the following section of this chapter, you will not be able to enroll yourself and/or them until the next Open Enrollment period (unless there is a Special Enrollment opportunity).

Failure to Provide Proof of Dependent Status: If you fail to provide proof of dependent status within 31 days of the effective date of coverage, the Plan will "pend" the dependent(s) confirmation of enrollment until such proof is provided although, the Plan will begin the required contribution for coverage. The dependent's eligibility status will be considered to be "pending proof of dependent status." Claims related to that dependent cannot be considered as payable under the Plan until such proof of dependent status is received by the Plan and determined by the Plan Administrator, or its designee, to meet the Plan's definition of Dependent Child and/or Spouse. No refund/reimbursement of premium contributions is made by this Plan if you enroll a dependent for coverage and fail to provide proof of dependent status or such proof does not satisfy the Plan's definition of Dependent Child and/or Spouse. Remember, you may drop dependents from coverage only at Open Enrollment or if you have a mid-year change of status that makes dropping a dependent consistent with the change of status event.

SPECIAL ENROLLMENT

A. Newly Acquired Spouse and/or Dependent Child(ren) (as these terms are defined under this Plan)

- **If <u>you are enrolled</u> for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)
- **If <u>you are eligible for coverage but not enrolled</u> for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for yourself and/or your new Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

- **If you did not enroll your Spouse for coverage** within 31 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your Spouse and/or your new Dependent Child(ren) and/or any Dependent Child(ren) no later than 31 days after the date of your new Dependent Child(ren)'s birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.
- To request Special Enrollment follow the procedure described under "Enrollment Procedure" in this chapter. To obtain more information about Special Enrollment, contact the County's Human Resources Benefits Unit.
- Under this Plan, Special Enrollment does pertain to a Domestic Partner or a child of a Domestic Partner.
- This Special Enrollment for birth, adoption, and marriage also applies to a retiree who is covered under this Plan. However, a retiree who declines coverage at retirement and later acquires a new dependent will not be entitled to special enrollment under this Plan, and neither will the retiree's dependents.

B. Loss Of Other Coverage

If, you did not request enrollment under this Plan for yourself, your Spouse, your Domestic Partner, and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you, your Spouse, your Domestic Partner, and/or any Dependent Child(ren) are eligible for coverage under this Plan but **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Spouse, your Domestic Partner, and/or any Dependent Child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage or CalCOBRA or Healthy Families Program or no share-of-cost Medi-Cal coverage, and such coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms (such as exceeding age or income limits for a Medi-Cal program); or
- the termination of a benefit package option under the other plan, unless substitute coverage offered; or
- the loss of eligibility due to reaching the lifetime benefit maximum <u>on all benefits</u> under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.
- You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military services, as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the Plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

See also the Enrollment Procedures section of this chapter for more information. Proof of loss of coverage is required by this Plan.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or

- because the 18-month, 29-month or 36-month (as applicable) period of COBRA Continuation Coverage has expired.

This Special Enrollment for loss of coverage <u>does NOT apply to a retiree</u>. Once a retiree loses coverage under this Plan, there is no opportunity for the retiree to re-enroll in the Plan. This means that a retiree who declines coverage at retirement from the County and later loses other coverage will not be entitled to the County's Special Enrollment due to a loss of coverage and neither will the retiree's dependents.

C. Special Enrollment Due to Medicaid Or A State Children's Health Insurance Program (CHIP):

A benefits-eligible employee or their eligible dependents may also enroll in this Plan if that employee or their eligible dependents:

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends. Note that if the individual requests enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

Coverage of an individual enrolling because of loss of other coverage or because of marriage: If the individual requests Special Enrollment **within 31 days** of the date of the event that created the Special Enrollment opportunity, (except for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment (see the exception below for newborns and adopted children).

If the individual requests enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.

- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 31 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
- For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated employees at Initial Enrollment.

Failure to Enroll During Special Enrollment (Very Important Information): If, as an employee, you fail to request enrollment for yourself and/or any of your Eligible Dependents within 31 days (or as applicable 60 days) after the date on which you and/or they first become eligible for Special Enrollment, you will not be able to enroll yourself or them until the next Open Enrollment period.

OPEN ENROLLMENT

Open Enrollment Period: Open Enrollment is the period of time during the spring of each year to be designated by the Plan Administrator during which eligible employees, retirees and COBRA qualified beneficiaries may make the elections specified below. Enrollment forms and information may be obtained from the County's Human Resources Benefits Unit. Individuals enrolled during Open Enrollment should follow the procedures explained at the time of Open Enrollment or the procedures described under "Enrollment Procedure" in this chapter.

Elections Available During Open Enrollment: During the Open Enrollment period, you (the employee, retiree and COBRA qualified beneficiary) may elect, for yourself and your Eligible Dependents who are eligible for coverage, to

- **enroll** in one of the health plans offered by the Plan (retirees may not newly enroll), or
- **add or drop** Eligible Dependents to the medical coverage (retirees may only drop), or
- **change** health plans, or
- other opportunities available to Plan participants, as announced during the Open Enrollment period.

Restrictions on Elections During Open Enrollment: No Dependent may be covered unless you are covered. You and all your covered Eligible Dependents must be enrolled for the same medical coverages. All relevant parts of the enrollment form must be completed and the form must be submitted before the end of the Open Enrollment period to the County's Human Resources Benefits Unit along with proof of Dependent status (as requested). See also the Enrollment Procedures section earlier in this chapter for more information.

Start of or Changes to Coverage Following Open Enrollment:

- If you or your Spouse, Domestic Partner, or Dependent Child(ren) are **enrolled for the first time during an Open Enrollment period**, that person's coverage will begin on the first day of the new Plan Year following the Open Enrollment.
- If you or your Spouse, Domestic Partner, or Dependent Children are **changing or discontinuing coverage during Open Enrollment**, such changes will become effective on the first day of the new Plan Year following Open Enrollment.

Failure to Make a New Election During Open Enrollment:

- If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the same medical coverage you had during the preceding Plan Year.
- Note, that for employees **to participate in the Plan's Flexible Spending Account for the next Plan Year** the employee must complete a new Flex Plan enrollment form, even if you were enrolled in the Flex plan the previous year.
- **Caution:** Open Enrollment procedures can differ from the process outlined above and if so, the procedure on how to enroll at Open Enrollment time will be announced by the Plan at the beginning of the Open Enrollment period.

Failure to Enroll During Open Enrollment (Very Important Information): If, as an employee, you fail to enroll yourself and/or any of your Eligible Dependents within the Open Enrollment period (unless your Eligible Dependents qualify for Special Enrollment described in the previous section of this chapter), you will not be able to enroll yourself and/or them until the next Open Enrollment period.

Failure to Provide Proof of Dependent Status: If you fail to provide proof of dependent status within 31 days of the effective date of coverage, the Plan will "pend" the dependent(s) proof of enrollment until such proof is provided although, the Plan will begin the required contribution for coverage. The dependent's eligibility status will be considered to be "pending proof of dependent status." Claims related to that dependent cannot be considered as payable under the Plan until such proof of dependent status is received by the Plan and determined by the Plan Administrator, or its designee, to meet the Plan's definition of Dependent Child and/or Spouse. No refund/reimbursement of premium contributions is made by this Plan if you enroll a dependent for coverage and fail to provide proof of dependent status or such proof does not satisfy the Plan's definition of Dependent Child and/or Spouse. Remember, you may drop dependents from coverage only at Open Enrollment or if you have a mid-year change of status that makes dropping a dependent consistent with the change of status event.

LATE ENROLLMENT

This Plan does not offer a Late Enrollment provision. See the Special Enrollment or Open Enrollment provisions of this chapter.

NEWBORN DEPENDENT CHILDREN (Special Rule for Coverage)

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

(1) any child born to the subscriber, spouse or domestic partner will be enrolled from the moment of birth; and

(2) any child being adopted by the subscriber, spouse or domestic partner will be enrolled 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, spouse or domestic partner the right to control the health care of the child (in the absence of a written document, other evidence of the subscriber's, spouse's or domestic partner's right to control the health care of the child may be used); or

   (b) the subscriber, spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. The "written document" referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. **For coverage to continue beyond this 31-day period, the subscriber must submit a membership change form to the plan administrator within the 31-day period**.

Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. **Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child is not considered proper enrollment** of that child for coverage under this Plan. See the paragraph above for an explanation of proper newborn enrollment. See also the Special Enrollment provisions and the Enrollment Procedure in this chapter.

ADOPTED DEPENDENT CHILDREN (Special Rule for Coverage)

Your adopted Dependent Child will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, provided you follow the enrollment procedure of this Plan. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- **A Newborn Child who is Placed for Adoption** with you within 31 days after the child was born will be covered from the date the child was placed for adoption if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.
- **A Dependent Child adopted more than 31 days after the child's date of birth** will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you submit a completed written enrollment form that may be obtained from the County's Human Resources Benefits Unit and provide of proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage, within 31 days of the child's adoption or placement for adoption.

If the adopted Dependent child is not properly enrolled in a timely manner, you must wait to enroll them at the next Open Enrollment period or Special Enrollment period, if applicable. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and Enrollment Procedure in this chapter.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR THE COUNTY OF SONOMA: (Special Rule For Enrollment)

1. No individual may be covered under this Plan as both an employee and a retiree. No individual may be covered under this Plan both as an employee or retiree and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one employee or retiree.
2. **If both you and your Spouse or Domestic Partner are eligible employees of the County of Sonoma**:
   - One of you must be designated as the eligible employee who can file the medical coverage choices for the entire family, including the other employee as a Spouse, Domestic partner, and all Dependent Children. The Spouse or Domestic partner who is **not** designated as the eligible employee may not make any independent coverage elections under the Plan. No dual coverage is allowed under the Plan.
   - If the Spouse or Domestic Partner who selected coverage as an employee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the benefits-eligible employee who was covered as Spouse will immediately be deemed eligible to have employee coverage, and the employee who had employee coverage will immediately be deemed eligible to be covered as a Spouse or Domestic Partner, and all Dependent Children will retain their coverage. Contributions for Dependent coverage will be deducted from the pay of the employee-Spouse who is now deemed to be the eligible employee. As a result, neither employee will sustain a loss of coverage because of termination of employment or reduction in hours, if a completed written enrollment form is submitted to the County's Human Resources Benefit Unit within 31 days.
   - The employee-Spouse/Domestic partner who is then deemed to be the eligible employee will have the option to terminate the coverage of the Spouse, Domestic partner, or any Dependent Child or otherwise elect any alternative coverage available under the Plan for the family members provided such election is, in the judgment of the Plan Administrator or its designee, consistent with the change in the family's circumstances as a result of the termination of employment or reduction in hours.
3. **If, while your family coverage is in effect, any of your Dependent Children becomes an employee of the County of Sonoma and becomes eligible for coverage as an employee**:
   - That child will cease to be a Dependent Child, and may enroll for coverage as an employee. Coverage as a Dependent Child will terminate as of the date coverage as a benefits-eligible employee becomes effective.
   - If the employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the employee-child will immediately be deemed eligible to be covered as a Dependent Child of the employee-parent. As a result, the employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours, if a completed written enrollment form is submitted to the County's Human Resources Benefits Unit within 31 days. Premium contributions for Dependent coverage will be deducted from the pay of the employee-parent, and will be adjusted as may be required when a Dependent Child becomes an employee and ceases to have coverage as a Dependent Child, or when the employee-child ceased to be an employee and resumes coverage as a Dependent Child.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (Special Rule for Enrollment)

1. This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that

creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

2. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).
4. **Enrollment Related to a Valid QMCSO:** If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.
   a. **If the employee is already a Plan Participant**, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
   b. **If the employee is not a Plan Participant** when the QMCSO is received and if the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the benefits-eligible employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
5. **Contributions for Coverage:** No coverage will be provided for any alternate recipient under a QMCSO unless the applicable employee contributions for that alternate recipient's coverage are paid, and all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the employee and all members of the employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the employee.
6. **Termination of Coverage:** Generally coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA chapter of this document.
7. **Additional Information:** For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the County's Human Resources Benefits Unit. See also the Claim Filing and Appeal Information chapter of this document for payment of claims under QMCSOs.

PAYMENT FOR YOUR COVERAGE

A. If you are eligible for and wish to be covered for Medical Plan benefits, you may be required to make a contribution for each of the benefits you choose. The County pays the difference between the full cost of the entire benefits program and the amount contributed by employees and retirees. As a result, your contributions pay part of the cost of coverage for yourself and, where applicable, your Dependents. The amount that you and the other employees or retirees pay for medical coverage: depends on the Medical Plan option selected and whether dependent coverage is elected.

   The specific amount you must pay for coverage is announced annually during the Open Enrollment period or you can contact the County's Human Resources Benefits Unit for information.

B. Employees pay contributions for healthcare coverage on a **before-tax** (pre-tax) basis. This means that payments for these coverages come from the employee's pay before federal, and in most cases, state taxes are withheld. That way, the employee should pay less in taxes. The before-tax contributions an employee makes toward coverage may lower the annual pay used to determine their Social Security benefits if the employee retires or is disabled. However, because Social Security benefits are calculated on the employee's annual income over the course of their career, with limits and adjustments made according to complex formulas, the effect (if any) of before-tax contributions is likely to be minimal.

C. NOTE: If you elect coverage for a Domestic Partner (as defined in this Plan), the contributions you make toward the cost of this coverage, and any children of the Domestic Partner, may need to be deducted on an after-tax basis, in accordance with certain applicable state law regulations. In addition, the amount the County pays toward the cost of your Domestic Partner coverage, and coverage for the children of Domestic Partners may need to be imputed as income and therefore is taxable to the employee. If you have questions about the state tax implications of covering a Domestic Partner or child or a Domestic Partner contact the County's Auditor, Controller, Treasurer, Tax Collector – Payroll Department.

CHANGING YOUR COVERAGE DURING THE YEAR (Mid-Year Change of Status/Election Change)

Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year (from June 1 to May 31), but you may be able to make some changes during the year (mid-year) if the Plan Administrator or its designee determines that you have a permissible **change** in your status (as permitted by the IRS) affecting your benefit needs. Under this Plan, for consistency, these mid-year change rules apply to individuals with pre-tax benefits and to individuals whose benefits are not provided pre-tax. The following changes are the only ones permitted under the Plan on a mid-year basis:

1. **Change in employee's legal marital or domestic partnership status**, including gaining a Spouse/Domestic Partner, or losing a Spouse/Domestic partner, legal separation (where permissible by law), annulment or death.
2. **Change in number of employee's Dependents**, including gaining a child through birth, adoption, or placement for adoption, or losing a child such as through death.
3. **Change in your, your Spouse's, Domestic Partner's or Dependent Child's employment status or work schedule if it impairs (or creates) your, your Spouse's, Domestic Partner's, or your Dependent Children's eligibility for benefits**, including the start or termination of employment, an increase or decrease in hours of employment (including a switch in part-time and full-time employment), a strike or lock-out, the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change of work-site.
4. **Change in Dependent status that satisfies or ceases to satisfy the Plan's eligibility requirements**, including changes due to attainment of age, or a change affecting a requirement described under the definition of Dependent in this document.
5. **Change of residence or worksite that allows or impairs** your, your Spouse's, Domestic Partner's, or Dependent Child's eligibility for benefits.
6. **Change required under the terms of a Qualified Medical Child Support Order (QMCSO),** including a change necessary to add the child as a covered Dependent as specified in the order, or to cancel coverage for the child if the order requires your former Spouse to provide that coverage.
7. **Change consistent with your right to Special Enrollment** as described in the section dealing with Special Enrollment in the Eligibility chapter of this document.
8. **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting you, your Spouse, you Domestic partner, or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.
9. **Automatic Change in the Cost of Coverage**. If the cost of a qualified benefits plan increases or decrease during the Plan year and under the terms of the Plan employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected employees' elective contribution for the Plan.
10. **Significant Change in the Cost of Coverage**. If the cost charged to an employee for a benefit package significantly increases or significantly decreases during the Plan year, the Plan may permit the employee to make a corresponding change in election under the Plan. In such a case the employee may start coverage in the Plan option with the decreased cost; or, revoke coverage in the Plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.
11. **Significant curtailment without loss of coverage**. If the employee or employee's Spouse, Domestic Partner, or Dependent child has a significant curtailment of coverage under a plan during the Plan year that is not a loss of coverage, the Plan may permit the employee who has been participating in the Plan to revoke his/her election for that coverage and elect to receive, on a prospective basis, coverage under another benefit package option providing similar coverage, or to drop coverage if no similar benefit package option is available. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.

12. **Addition or elimination of a benefit package option providing similar coverage**. If during a Plan Year, the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) the Participant may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
13. **Addition or significant improvement of any Plan option under the employer's Health Care Programs or the Spouse's/Domestic Partner's employer's health care plans or programs**. In such a case, a Participant may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.
14. **Change in coverage under another employer's plan or program** that permits Participants to make an election change that would be permitted by these mid-year changes, or that permits Participants to make an election for a period of coverage that is different from the Plan Year of this Plan (e.g. Spouse's employer coverage has different open enrollment/Plan year). In such a case, a Participant may elect, on a prospective basis, the same change in coverage under this Plan that was available under the other plan.
15. **Reduction of Hours.** An employee who was expected to average at least 30 hours of service per week may prospectively drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the mid-year change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage (MEC). The new MEC coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped. [For example, other minimum essential coverage could mean intended enrollment in Health Insurance Marketplace coverage, minimum essential coverage through the spouse's group health plan, to change to a different medical plan option of the employee's own employer or to enroll in Medicaid/CHIP.
16. **Exchange Coverage.** An employee who is eligible to enroll in Marketplace coverage (during a Marketplace special enrollment or open enrollment period) may prospectively drop the County's group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Marketplace coverage that is effective no later than the day after the last day of the original coverage. This means that the County's group health plan coverage is not to be terminated until Marketplace coverage takes effect.

These rules apply to making changes to your benefit coverage(s) during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status; *(For example, if mid-year, the employee and Spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the Spouse from coverage at this time)*; **and**
2. You must notify the Plan in writing within 31 days of the change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage. (You have 60 days from the loss of eligibility for Medicaid or CHIP to request to enroll in this Plan as discussed under Special Enrollment); **and**
3. If you have a permissible change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan. Proof of the change event will be required; **and**
4. If you will be adding an individual to the Plan, **coverage changes associated with a mid-year change of status opportunity must be prospective** and are therefore effective the first day of the month following the change provided you submit a completed a written benefit change form to the County's Human Resources Benefits Unit, except for:
   - Newborns, who are effective on the date of birth and
   - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If you experience the following Event...	You may make the following change(s) within 31 (or if applicable 60) days of the Event.	YOU MAY NOT make these types of changes...
REMINDER: *Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.*		
Life / Family Events		
Marriage or Commencement of Domestic Partnership (DP)	• Enroll yourself, if applicable • Enroll your new Spouse or Domestic partner and other eligible dependents • Drop health coverage (to enroll in your Spouse's or Domestic partner's plan) • Change health plans (for commencement of Domestic Partnership only if the event provides Domestic Partner with new status as tax-qualified dependent)	• Drop health coverage and not enroll in Spouse's or Domestic Partner's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	• Remove your Spouse or Domestic Partner from your health coverage • Drop dependent child(ren) if show proof of other coverage under spouse's plan • Children of a Domestic Partner MUST be dropped (regardless of whether they enroll in other coverage) as they are no longer eligible dependents • Enroll yourself and your dependent children if you or at least one dependent child was previously enrolled in your Spouse's or Domestic Partner's plan and lost eligibility • Change health plans	• Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Adoption placement papers are required • Change health plans	• Drop health coverage for yourself or any other covered individuals without proof of enrollment in spouse/DP's plan
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Drop child named on QMCSO if required by QMCSO • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Drop health coverage for yourself • Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (*e.g.* child reaches the maximum age for coverage)	• Remove the child who lost eligibility from your health coverage • Change health plans to accommodate newly removed dependent(s) and remaining covered individuals	• Drop health coverage for yourself or any other covered individuals
Death of a dependent (Spouse, Domestic Partner, or child)	• Remove the deceased dependent from your health coverage • Enroll yourself and/or any eligible children if lost eligibility under spouse's/DP's plan • Change health plans to accommodate newly removed dependent(s) and remaining covered individuals	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to Medicare	• Drop coverage for the person Dependent who became entitled to Medicare with proof of Medicare enrollment • If Employee becomes entitled to Medicare, may drop all coverage (self and dependents) • Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).		
If you experience the following Event...	**You may make the following change(s) within 31 (or if applicable 60) days of the Event.**	**YOU MAY NOT make these types of changes...**
Covered person lost entitlement to Medicare	• Add the person who lost entitlement to Medicare and all other eligible dependents • Change health plan to accommodate newly enrolled dependents	• Drop coverage for yourself or any enrolled dependents
Change of home address outside of plan service area that causes a loss of eligibility for coverage	• If you are enrolled in an HMO and move out of their service area, then you can change health plans	• Cannot add eligible dependents • Does not apply to County Health Plan, dental or vision coverage
If you experience the following Event...	**You may make the following change(s) Within 60 days of the Event…**	**YOU MAY NOT make these types of changes**
Covered person has become entitled to Medicaid, Medi-Cal, or SCHIP [2]	• Drop coverage for the Dependent who became entitled to Medicaid, Medi-Cal, or SCHIP with proof of Medicaid, Medi-Cal or SCHIP enrollment • Drop coverage for yourself with proof of your own Medicaid/Medi-Cal/SCHIP enrollment o Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person lost entitlement to Medicaid, Medi-Cal or SCHIP	• Add the person who lost entitlement to Medicaid, Medi-Cal, or SCHIP • If you or an eligible dependent is gaining eligibility for premium assistance, may enroll those gaining eligibility for premium assistance only if not already enrolled in County coverage	• Drop coverage for yourself or any enrolled dependents • Change plans
Employment Status Events		
If you experience the following Event...	**You may make the following change(s) within 31 days of the Event…**	**YOU MAY NOT make these types of changes**
You become newly eligible for benefits due to change in employment status or bargaining group	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents	Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse or Domestic Partner obtains health benefits in another group health plan	• Remove your Spouse or Domestic Partner from your health coverage • Drop your dependent children from your health coverage if they enroll in spouse's or Domestic Partner's coverage • Drop coverage for yourself if you enroll in your spouse's/Domestic Partner's coverage • Proof of coverage in the other health plan required	• Change health plans. • Add any eligible dependents to your health coverage. • Enroll yourself if you are not currently enrolled

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).		
If you experience the following Event...	**You may make the following change(s) within 31 (or if applicable 60) days of the Event.**	**YOU MAY NOT make these types of changes...**
Spouse or Domestic Partner loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage or eligibility for health benefits in another group, individual, or exchange health plan. You or your dependents exhaust COBRA coverage under other group health plan.	• Enroll your Spouse or Domestic Partner and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's or Domestic Partner's plan • Change health plans • Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You experience a significant increase in your employee cost of coverage. - Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.	• Drop coverage for yourself (only if there is a significant cost change and there is no other similar health plan option available) • Change health plans to a less expensive plan	• Cannot drop dependents from coverage if employee does not drop coverage.
You experience a significant decrease in your employee cost of coverage.	• Enroll yourself if not currently enrolled • Change health plans to the decreased cost plan	• Add or Drop any dependents • Drop coverage for yourself
You experience a non-FMLA leave of absence (paid or unpaid leave)	• You may suspend (not drop) coverage for yourself and dependents while on leave and reinstate coverage upon return to work if you are still eligible then.	• Add or Drop any dependents, change plans, or enroll if not currently enrolled
You experience an FMLA leave of absence (paid or unpaid leave)	• An employee on FMLA must be permitted to drop coverage or continue coverage while on leave.	• Add or Drop any dependents, change plans, or enroll if not currently enrolled

You, your spouse, or dependents enroll in a Qualified Health Plan through a Public health Insurance Marketplace	• Drop your spouse/DP from your health coverage
	• Drop your dependent children from your health coverage
	• Drop coverage for yourself
	  • Proof of enrollment in Marketplace Coverage is required.
	  • Employee may prospectively drop coverage through the County if doing so corresponds with employee's intended enrollment of him/herself (and all currently enrolled dependents) in Marketplace coverage that is effective no later than the day after the last day of coverage under the County's Plan.
		• Add any dependents, change plans, or enroll yourself if not currently enrolled

Proof of a status change may be required to make a corresponding change in coverage/enrollment.		

MOVING OUTSIDE THE EPO PLAN'S SERVICE AREA

If you are enrolled for coverage in the Plan's Exclusive Provider Organization (EPO) that provides benefits for covered healthcare services if they are provided within a specified geographic service area; **and** you move your residence to a place outside that service area; then you may enroll in any alternative medical plan coverage provided by the County, if you submit a completed enrollment form within 31 days after moving out of the service area; and pay any required contribution for the new medical plan coverage.

WHEN COVERAGE ENDS

Employee coverage ends on the earliest of:

- the last day of the month in which your employment ends; or

- the last day of the month in which you enter the Armed Forces (the military) on full-time active duty; or
- the last day of the month in which you are no longer eligible to participate in the Plan; or
- the last day of the month in which you cease to make any contributions required for your coverage; or
- the date the Plan is discontinued; or
- the date of your death.

Retiree coverage ends on the earliest of:

- the last day of the month in which the Retiree fails to make any required premium contributions for coverage; or
- the date of the Retiree's death; or
- the date the Plan is discontinued; or
- the last day of the month prior to the month in which the Retiree becomes covered under a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD);
- the date Retiree coverage is discontinued under the Plan.

Dependent or Domestic Partner coverage ends on the earliest of:

- the last day of the month in which the Employee's coverage ends; or
- the last day of the month in which the covered Spouse or Dependent Child(ren) or Domestic Partner no longer meet the definition of Spouse or Dependent Child(ren) or Domestic Partner as provided in the Definitions chapter of this document; or
- for Dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO; or
- the last day of the month in which you cease to make any contributions required for coverage of your Spouse or Dependent Child(ren) or Domestic Partner; or
- the last day of the month in which the date the Spouse, Dependent Child or Domestic Partner enters the Armed Forces on full-time active duty; or
- the date Dependent coverage is discontinued under the Plan;
- the date of the Dependent's or Domestic Partner's death;
- the date the Plan is discontinued.

OPTIONS WHEN COVERAGE UNDER THIS PLAN ENDS

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA, or you can look into your options to buy an individual insurance policy for health care coverage from the Health Insurance Marketplace.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov or visit www.coveredca.com.

Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

- When coverage under this Plan terminates, remember that you have options to consider in order to avoid the Individual Mandate penalty. For more information on the Individual Mandate, talk with your tax advisor or visit http://www.healthcare.gov/.

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums, contributions, and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. For example, keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, ex-Domestic Partner, over-age or ineligible dependent child, etc.) is considered fraud.

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If you are a totally disabled subscriber or a totally disabled dependent and under the treatment of a physician on the date of discontinuance of the plan, your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. This Extension is offered as an alternative to COBRA continuation coverage, when COBRA continuation coverage is available, and therefore either COBRA or this Extension may be elected. 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. A period of up to 12 months has passed since your extension began.

LEAVE OF ABSENCE (Special Circumstances)

You may be able to continue coverage under this plan under certain conditions.

- **Leave of Absence.** If you take a leave of absence without pay during the time which your eligibility would normally terminate, you may continue your coverage by making the required payments for the cost of plan benefits for yourself and your eligible dependent(s). Benefit coverage may be continued in this manner only for such a term that is consistent with the County's Leave of Absence policy. Contact the County's Human Resources Disability Management Unit for more information about leave of absence. See also the FMLA leave and USERRA leave sections below.

- **Disability.** If you file a disability retirement application prior to termination of coverage under this Plan, you may elect to continue coverage for yourself or your eligible dependent(s) (for no longer than 6 months) by making the required payments for the cost of coverage until such time as the Sonoma County Employees' Retirement Association (SCERA) announces its decision on your disability retirement application. You may be reimbursed for payments made for coverage after the effective date of your retirement.

If you wish to continue coverage under either of the circumstances above (unpaid leave or disability) you must make the required payments to the County prior to the month for which coverage is requested and in accordance with the schedule provided by the County. If you fail to make a timely payment, you cannot resume self-payments at a later time (except under COBRA).

Family and/or Medical Leave (FMLA)

In general, to be eligible for FMLA, an employee must have worked for their employer for at least 12 months, met the 1,250 hours of service requirement in the 12 months prior to the leave, and worked at a location where the employer employed at least 50 employees within 75 miles. If the employee is eligible for FMLA the employee is entitled by law to up to 12 weeks each year (in some cases, up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a Spouse, child or parent who is seriously ill, or for the employee's own serious illness.

Under this Plan a FMLA leave can be used to care for a Domestic Partner or child of a Domestic Partner that is seriously ill.

For the calculation of the 12-month period used to determine employee eligibility for FMLA, this Plan uses a rolling 12 month period measured backward in time from the date the employee uses any FMLA leave.

While you are officially on such a family or medical leave, you can keep medical coverage for yourself and your Dependents and Domestic Partner or child of a Domestic Partner in effect during that family or medical leave period by continuing to pay your contributions for that leave period.

- Since you will not be paid while you are on family or medical leave, you may pay your contributions as they come due on the dates you would have been paid or on some other schedule agreed to by you and the County had you not taken family or medical leave, in which case your contributions will be made on an after-tax basis; or you may elect to have extra contributions withheld from your pay before you begin your family or medical leave, in which case your contributions will be made on a before-tax basis.
- Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, and you are in a benefits-eligible position, your health care coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents and Domestic Partner or child of a Domestic Partner who were covered by the Plan at the time you took your leave.
- Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Dependents and Domestic Partner or child of a Domestic Partner in the same way they apply to all other employees and their Dependents and Domestic Partner or child of a Domestic Partner. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact the County's Human Resources Disability Management Unit.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the County's Human Resources Benefits Unit to obtain a copy of the COBRA

or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the County's Human Resources Benefits Unit.

County-Approved Leave of Absence

Upon approval by your employer and in accordance with the County's leave policies for its employees, an employee may be granted a leave of absence that is not on account of FMLA or USERRA. In these situations, the County determines if benefits are to be continued for the employee during the County-Approved Leave of Absence. If not, COBRA Continuation Coverage will be offered. If benefits are to be continued during the leave, the County will make arrangements to collect the appropriate premium contributions for the employee and any covered dependents during the leave period, in order for coverage to continue during the County-approved leave of absence. For details of the approved leave including income, accumulation of vacation or sick time, continuation of applicable benefits, refer to the County's Auditor, Controller, Treasurer, Tax Collector – Payroll Department.

NOTICE TO THE PLAN

You, your Spouse, your Domestic Partner or any of your Dependent Children **must notify the Plan preferably within 31 days but no later than 60 days*** after the date a:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce);
- Dependent Child ceases to meet the Plan's definition of Dependent (such as the Dependent Child reaches the Plan's limiting age or the Dependent Child age 26 and older ceases to have any physical or mental disability);
- Domestic Partner ceases to meet the Plan's definition of Domestic Partner.

***Failure to give this Plan a timely notice (as noted above) may cause** your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

CONTINUATION OF COVERAGE

See the COBRA chapter for information on continuing your health care coverage.

MEDICAL EXPENSE BENEFITS

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expense." Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **"Medically Necessary,"** but only to the extent that the charges are **"Maximum Allowed Amount"** (as those terms are defined in the Definitions chapter of this document). In addition, if these services are received from a non-participating provider, you may be billed by the provider for the difference between their charges and the maximum allowed amount. In many situations, this difference could be significant. The fact that a physician prescribes or orders the service does not, in itself, make it medically necessary or a covered expense; and
2. **not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **not services or supplies in excess** of a Maximum Plan Benefit as shown in the Schedule of Medical Benefits; and
4. **for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document or where prophylactic surgery/treatment is determined to be medically necessary by the Plan); and
5. **incurred while you are covered under this Plan**. An expense is incurred on the date you receive the service or supply for which the charge is made.

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. In some cases, you may be required to pay the entire maximum allowed amount. For instance, if you have not met your Deductible under this Plan, then you could be responsible for paying the entire maximum allowed amount for covered services. The Medical plans in this document do not contain a pre-existing condition limitation.

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Maximum Allowed Amount ~~Maximum Allowed Amount~~, not covered by the Plan, in excess of a Maximum Plan Benefit or payable on account of a penalty because of failure to comply with the Plan's Utilization Review requirements as described later in this document.

NETWORK HEALTH CARE PROVIDER SERVICES

- **In-Network:** If you receive medical services or supplies from a Health Care Provider/Facility that is contracted with the Plan's PPO/EPO network you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with the PPO/EPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional copayments, deductibles or coinsurance you are responsible for paying, as payment in full, except with respect to claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO/EPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge in excess of what this Plan considers a Maximum Allowed Amount.
- **Out-of-Network (also called Non-Network, Non-PPO, Non-EPO or Non-Participating):** refers to providers/facilities not contracted with the Anthem Prudent Buyer PPO/EPO Network and who do not generally offer any fee discounts to the participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Maximum Allowed Amount payable by the Plan, also called balance billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. To avoid balance billing, use in-network PPO/EPO providers.

See also the Medical Networks chapter of this document.

IMPORTANT: For **EPO Plan** Participants, there is **<u>no coverage</u>** from NON-network providers except if you have an authorized referral from a network provider or if you have an emergency.

AUTHORIZED REFERRAL

In some circumstances the Medical Plan claims administrator may authorize participating provider cost share amounts (Deductibles, Coinsurance or Copayments) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the Medical Plan claims administrator in advance of obtaining the covered service. It is your responsibility to ensure that the claims administrator has been contacted.

If the claims administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. If you receive prior authorization for a non-participating provider due to network adequacy issues, you will not be responsible for the difference between the non-participating provider's charge and the maximum allowed amount. Please call the Member Services telephone number on your ID card for authorized referral information or to request authorization.

DEDUCTIBLES

The annual deductible is the amount you must pay each plan year (which is June 1 to May 31) before the Plan begins to pay benefits. Each plan year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. There are two types of annual Deductibles: Individual and Family.

- The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin. The Plan's Individual Deductible is listed on the Schedule of Medical Benefits.
- The **Family Deductible** is the maximum amount that a family of two or more persons is responsible for paying toward Eligible Medical Expenses before Plan benefits begin. The Plan's Family Deductible is listed on the Schedule of Medical Benefits. For any given family member, the Deductible is met either after he/she meets the Individual Deductible, or after the entire Family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member.

Information About Deductibles:

- Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.
- The amount applied to the deductible is the lesser of billed charges or the amount considered to be a Maximum Allowed Amount under this Plan.
- Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles.
- Copayments and penalties for failure to obtain preauthorization for services do not accumulate to meet a Deductible.
- Certain Eligible Medical Expenses are not subject to Deductibles, such as preventive services. These expenses may be covered 100% by the Plan, or they may be subject to Copayments or Coinsurance (explained below). See the Schedule of Medical Benefits to determine when Eligible Medical Expenses are not subject to Deductibles.
- Retail and Mail Order prescription drug copayments do not accumulate to meet the annual Medical Plan deductible.

COINSURANCE

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, and any copayments required, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. The coinsurance related to a covered benefit is described on the Schedule of Medical Benefits.

If you use the services of a Health Care Provider who is a member of the Plan's PPO or EPO, you will be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network chapter of this document.

Coinsurance When You Don't Comply with Utilization Review Programs: If you fail to follow certain requirements of the Plan's Utilization Review Program (as described in the Utilization Review chapter of this document) the Plan may pay a smaller percentage of the cost of those services, and you will have to pay a greater percentage of those costs, or the Plan will not pay any benefits toward the service not precertified, and the additional amount you'll have to pay will not accumulate to meet the Plan's Deductibles described below. See also the Utilization Review chapter of this document.

COPAYMENT

A copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan's copayments are indicated on the Schedule of Medical Benefits. Copayments are not used to satisfy a Deductible. Copayments do accumulate to the Out-of-Pocket Limit under the medical plan options (see the section on Out-of-Pocket Limit below).

OUT-OF-POCKET LIMIT (ANNUAL LIMIT ON IN-NETWORK COST SHARING)

This Plan has an **Out-of-Pocket Limit** which limits your annual cost-sharing for covered health benefits related to Medical Plan deductibles, coinsurance, and copayments to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket Limit is the most you pay during a one year period (the plan year which is June 1 to May 31) before your medical plan starts to pay 100% for covered health benefits. The amount of the Out-of-Pocket Limit is explained on the Schedule of Medical Benefits.

- **Under the PPO Plan**, covered medical plan expenses from In-Network and Out-of-Network providers accumulate to the Out-of-Pocket Limit. There is a separate Out-of-Pocket Limit that accumulates only outpatient prescription drug benefits.
- **Under the EPO Plan** covered medical plan expenses from In-Network providers accumulate to the Out-of-Pocket Limit. There is no coverage for the use of Out-of-Network providers, except that covered emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the in-network Out-of-Pocket Limit. There is a separate Out-of-Pocket Limit that accumulates only outpatient prescription drug benefits.
- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
- The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.

The Medical Plan Out-of-Pocket Limit does not include or accumulate:

a. Premiums and/or contributions for coverage,

b. Expenses for medical services or supplies that are not covered by the Plan,

c. Charges in excess of the Maximum Allowed Amount determined by the Plan which includes balance billed amounts for non-network providers,

d. When enrolled in the EPO Plan, expenses for the use of non-network providers, except covered emergency services performed in an Out-of-Network Emergency Room, or with an authorized referral from an EPO provider),

e. Charges in excess of the Medical Plan's maximum benefits.

f. Outpatient prescription drugs (These drugs accumulate to a separate limit described in the Drug row of the Schedule of Medical Benefits).

MAXIMUM PLAN BENEFITS

Types of Maximum Plan Benefits: There are two general types of maximum amounts of benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan: the Limited Overall Maximum Plan Benefit and Annual Maximum Plan Benefit. They are described below and the amount of the benefit maximums are listed on the Schedule of Medical Benefits.

- **Limited Overall Maximum Plan Benefits:** Certain Plan benefits are subject to limitations that are not considered Annual maximums, and are called Limited Overall Maximums. An example would be a limit per device or per body part or per occurrence. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical Benefits.

  Once the Plan has paid the Limited Overall Maximum Plan benefit for any of those services or supplies on behalf of any Covered Individual, no further Plan benefits will be paid for those services or supplies on account of that Covered Individual.

- **Annual Maximum Plan Benefits:** Plan benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Covered Individual or family during each Plan Year. Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual or family, no further Plan benefits will be paid for those services or supplies on account of that Individual or family for the balance of the Plan Year. The services or supplies that are subject to an Annual Maximum Plan Benefit are identified in the Schedule of Medical Benefits.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. It has been determined that the prescription drug coverage under the EPO Plan and PPO Plan outlined in this document is "creditable". "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan. Generally you may only drop medical plan coverage at this Plan's next Open Enrollment period.

Medicare-eligible people can enroll in a Medicare Part D Prescription Drug Plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving employer group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Medicare Part D Notice of Creditable Coverage (a copy is available from the County's Human Resources Benefits Unit). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

If you or your Medicare-eligible Dependent(s) enroll in a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD), you **will not** be eligible to receive any prescription drug or medical benefits from this Plan.

If you or your Medicare-eligible Dependent(s) enroll in a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage plan, and you later change your mind, you *may not* re-enroll in this Plan *at any time*. Note that since coverage is available to you and your Dependents as a family unit, if you or any of your Medicare-eligible Dependent(s) enroll in a PDP or Medicare Advantage plan, the rules will apply to the entire family.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The PPO and EPO medical plans in this document **do not** require the selection or designation of a primary care provider (PCP). You have the ability to visit any Network or Non-Network health care provider; however, payment by the PPO Plan may be less for the use of a Non-Network provider. Under the EPO Plan there is no coverage for the use of Out-of-Network providers, except for emergency services performed in an Out-of-Network Emergency Room.

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

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan at the phone number on your ID card.

NONDISCRIMINATION IN HEALTH CARE

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

SCHEDULE OF MEDICAL BENEFITS

A schedule of the Plan's Medical Benefits, appears on the following pages in a chart format. Each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided by the PPO Plan and EPO Plan for In-Network Providers and Out-of-Network Providers are shown in the subsequent columns.

Deductibles, Out-of-Pocket Limits, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed first because these categories of benefits apply to most (but not all) health care services covered by the Plan. They are followed by descriptions, appearing in **alphabetical** order, of all other benefits for specific health care services and supplies that are frequently subject to limitations and exclusions.

All benefits shown in the Schedule of Medical Benefits are subject to the Plan's Deductibles unless there is a specific statement that the deductible does not apply.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions chapter of this document to see if they are excluded.

TIME LIMIT FOR INITIAL FILING OF MEDICAL PLAN CLAIMS

Certain timing claim filing requirements pertain to network providers; otherwise, all claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information.

The Plan is not legally required to consider information submitted after the stated timeframe.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*

Deductible
• The annual deductible is the amount you must pay each plan year (June 1 to May 31) before the Plan begins to pay benefits.
• There are two types of Annual Deductibles: Individual and Family.
  • The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin.
  • The **Family Deductible** is the maximum amount that a family of two or more persons is responsible for paying toward Eligible Medical Expenses before Plan benefits begin. For any given family member, the Deductible is met either after he/she meets the individual Deductible, or after the entire family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member.
• Each plan year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits.
• Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.
	• The amount applied to the deductible is the lesser of billed charges or the amount considered to be a Maximum Allowed Amount under this Plan.
	• Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductible.
	• Copayments and penalties for failure to obtain preauthorization for services do not accumulate to meet a Deductible. Retail and Mail Order prescription drug copayments do not accumulate to meet the annual Medical Plan deductible.
	• Certain Eligible Medical Expenses are not subject to Deductibles as explained in this Schedule. These expenses may be covered 100% by the Plan, or they may be subject to Copayments. For example, **a Deductible does not apply to**:
	a) preventive services in accordance with Health Reform;
	b) outpatient prescription drug benefits;
	c) office visits to a physician who is an in-network provider. This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc. ;
	d) diabetes education program services;
	e) urgent care services when provided by a physician who is a participating provider;
	f) transplant travel expenses authorized by the Medical Plan Claims Administrator;
	g) bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated Center of Medical Excellence (COE).
		$300 per person
		
		$900 per family
				$500 per person
				
				$1,500 per family
					No coverage out-of-network except in an emergency, or with an authorized referral from an EPO Physician

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

<table>
<tr><th rowspan="2">BENEFIT DESCRIPTION</th><th rowspan="2">EXPLANATIONS AND LIMITATIONS OF BENEFITS</th><th colspan="2">CHP PPO Plan</th><th colspan="2">CHP EPO Plan</th></tr>
<tr><th>In-Network</th><th>Out-of-Network*</th><th>In-Network</th><th>Out-of-Network*</th></tr>
<tr>
<td><u>Out-of-Pocket Limit</u>
• The EPO and PPO Medical Plans have an Out-of-Pocket Limit which limits your annual cost-sharing for covered health benefits related to Medical Plan deductibles, coinsurance, and copayments.
• The Out-of-Pocket Limit is the most you pay during a one year period (the plan year which is June 1 to May 31) before the medical plan starts to pay 100% for covered health benefits.
• Under the PPO Plan, covered medical plan expenses from In-Network and Out-of-Network providers accumulate to the Out-of-Pocket Limit.
• Under the EPO Plan covered medical plan expenses from In-Network providers accumulate to the Out-of-Pocket Limit. Covered emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the in-network Out-of-Pocket Limit. <u>No coverage out-of-network except in an emergency, or with an authorized referral from an EPO provider</u>.
• The PPO and EPO medical plan Out-of-Pocket Limits do not accumulate outpatient drugs. There is a separate Out-of-Pocket Limit that accumulates only outpatient retail and mail order drug benefits.</td>
<td>• Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
• The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.
• The Medical Plan Out-of-Pocket Limit does not include or accumulate:
a. Premiums and/or contributions for coverage,
b. Expenses for medical services or supplies that are not covered by the Plan,
c. Charges in excess of the Maximum Allowed Amount determined by the Plan which includes balance billed amounts for non-network providers,
d. When enrolled in the EPO Plan, expenses for the use of non-network providers, except covered emergency services performed in an Out-of-Network Emergency Room, or with an authorized referral from an EPO provider.
e. Charges in excess of the Medical Plan's maximum benefits
f. Outpatient prescription drugs (see separate limit described in the Drug row of this Schedule).</td>
<td colspan="2">$2,300 per person

$4,900 per family

See also the Drug row for the separate limit for the outpatient retail and mail order drug benefits.</td>
<td>$5,500 per person

$11,500 per family

See also the Drug row for the separate limit for the outpatient retail and mail order drug benefits.</td>
<td>Covered emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the in-network Out-of-Pocket Limit.</td>
</tr>
</table>

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.

***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. • Specialty care units within the hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is a subscriber, an enrolled spouse or a domestic partner. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.	• **Elective (non-emergency) Hospitalization requires precertification** by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document**. All Hospitalization is subject to concurrent review.** See the Utilization Review chapter for details. • The admission copayment is waived for an emergency admission. • See also the dental row for payment of certain dental services under the Medical Plan. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered. • Specialty care hospitals, also called long term care acute (LTAC) hospitals, are discussed under the Skilled Nursing Facility row in this Schedule. • **WARNING! Reduction of the Maximum Allowed Amount for Non-Contracting Hospitals.** A small percentage of hospitals which are non-participating providers are also non-contracting hospitals. Except for emergency care, the maximum allowed amount **is reduced by 25%** for all services and supplies provided by a non-contracting hospital. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a contracting hospital. **To locate a contracting hospital, you can call the Member Services number** on your identification card (or Quick Reference Chart in the front of this document).	**Hospital facility fees:** After you pay the deductible and a $125 copay per admit, the Plan pays 90%. Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	**See WARNING to the left.** **Hospital facility fees:** After you pay the deductible and a $125 copay per admit, the Plan pays 60%. Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	**Hospital facility fees for <u>Maternity Delivery</u>:** After you pay the deductible and a $250 copay per admit, the Plan pays 80%. **All other Hospital facility fees:** After you pay the deductible and a $500 copay per admit, the Plan pays 80%. Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	Not covered.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, outpatient/ambulatory surgery center or other covered health care facility location.
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon;
  • Assistant surgeon (if Medically Necessary, including a Certified Surgical Assistant);
  • Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists (CRNA);
  • Pathologist; Radiologist;
  • Podiatrist (DPM);
  • Physician Assistant; Nurse Practitioner;
  • Certified Nurse Midwife.
• See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from in-network providers.
• See also the Emergency Services row for payment of providers in an emergency room.
	• **Some Physician & Health Care Practitioner Services including transplant-related services require precertification** by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document.
	• Eye exam is at no charge when performed as part of a preventive care visit to an in-network provider.
	• See also the definition of Physician, Health Care Practitioner and Surgery in the Definitions chapter.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Definitions chapter.
	• Under the PPO and EPO Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
		Office Visit: $20 copay per visit, no deductible
		
		Trans-plant related office visit: 90% after deductible met
		
		Urgent Care Physician fees: $20 copay per visit, no deductible
		
		All other physician and Health Care Practi-tioner Services: 90% after deductible met
			60% after deductible met	**Office Visit:** $50 copay per visit, no deductible
				
				All other physician and Health Care Practi-tioner Services: 80% after deductible met
					No coverage out-of-network except in an emergency, or with an authorized referral from an EPO provider.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician or Health Care Practitioner.	**Testing:** $20 copay per visit, no deductible **Allergy Shots:** Antigen: $20 copay per visit, no deductible	60% after deductible met	**Testing:** $50 copay per visit, no deductible **Allergy Shots:** Antigen: $50 copay per visit, no deductible	No coverage
Acupuncture Services • Acupuncture is payable to treat to treat intractable pain only, or conditions resulting therefrom, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.	• No acupuncture benefits will be payable unless services are performed by or referred by a Physician.	90% after deductible met	60% after deductible met	80% after deductible met	No coverage
Ambulance Services • **Ground vehicle emergency transportation** is payable to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness; • **Air/sea emergency transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for ambulance services are covered only when those services are for an **Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-facility transport. No coverage for non-emergency medical transportation. • The following ambulance services are covered: 1) Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital. 2) Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance if you believe you have an emergency medical condition requiring such assistance. 3) Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled **to the nearest hospital where appropriate treatment is provided** if, and only if, such services are medically necessary and ground ambulance service is inadequate. 4) Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.	**Emergency Transport:** 90% after deductible met	**Emergency Transport:** 90% after deductible met **Non-Emergency:** Not covered	**Emergency Transport:** 80% after deductible met	No coverage out-of-network except in an emergency.
Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.				

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Behavioral Health Services **(Mental Health and Substance Abuse Treatment)** • **Employee Assistance Program (EAP) Services**: This plan offers up to 6 free EAP visits/problem for professional confidential counseling. The phone number for the EAP program is listed on the Quick Reference Chart in the front of this document. • In addition to the EAP services the following benefits are available: • **Inpatient Acute hospital admission** or residential treatment program. • **Outpatient visits** including necessary Psychological (Psychiatric) Testing. • **Other outpatient services** such as: partial day care/partial day treatment.	• **All inpatient hospital stays, residential treatment center admissions for the treatment of mental health or substance abuse conditions requires precertification** by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • The admission copayment is waived for an emergency admission. • Non-Physicians include a psychologist, marriage and family therapist or licensed clinical social worker. • No coverage for Marriage counseling. See the EAP services. • See also the row on Pervasive Developmental Disorder or Autism services in this Schedule. • Note the specific exclusions related to Behavioral Health Services in the Exclusions chapter.	**Inpatient: Hospital and Residential Treatment Program:** After you pay the deductible and a $125 copay per admit, the Plan pays 90%. **Office Visit:** $20 copay per visit, no deductible **Other outpatient services and Inpatient Physician visit:** 90% after deductible met	**Inpatient: Hospital and Residential Treatment Program:** After you pay the deductible and a $125 copay per admit, the Plan pays 60%. **Office Visit Other outpatient services, and Inpatient Physician visit:** 60% after deductible met	**Inpatient: Hospital and Residential Treatment Program:** After you pay the deductible and a $500 copay per admit, the Plan pays 80%. **Office Visit:** $50 copay per visit, no deductible **Other outpatient services and Inpatient Physician visit:** 80% after deductible met	No coverage
Birthing Center/Facility	• See the Maternity Services row of this Schedule.				
Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Blood transfusions, including blood processing and the cost of un-replaced blood and blood products are covered. • 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.	Payment varies by location where blood is adminis-tered.	Payment varies by location where blood is adminis-tered.	Payment varies by location where blood is adminis-tered.	No coverage
Breast Reconstruction Services	• See the Reconstructive Services row of this Schedule.				

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home. Chemotherapy is the use of chemical or biological antineoplastic agents (drugs) to treat malignant diseases. • Chemotherapy can be delivered by any of the following methods: • Orally: Prescription drug in pill form taken by mouth. • Parenteral: Medication delivered by injection either intravenous, intramuscular and/or subcutaneous. • Infusion Pump: Medication delivered on a continuous basis through a pump, either a portable pump or an implantable pump. • Arterial perfusion: Medication delivered by injection through an artery. • Intracavitary: Medication injected into the space within an organ (e.g., bladder). • Intrathecal: Medication injected into tissue that surround internal organs (e.g., peritoneum).	• Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a Hospital, the Hospital Services coverage applies; if it is delivered at home or in a Physician's office, see Physician's and Other Health Care Practitioners (above) in this Schedule of Medical Benefits. • NOTE: Chemotherapy utilizing antineoplastic agents (drugs) that are not FDA approved are considered experimental/ investigational and excluded from coverage.	Payment varies by location in which chemo-therapy is delivered.	Payment varies by location in which chemo-therapy is delivered.	Payment varies by location in which chemo-therapy is delivered.	No coverage
Chiropractic Services	• See the Rehabilitation row of this Schedule of Medical Benefits.				

SCHEDULE OF MEDICAL BENEFITS

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<table>
<tr><th rowspan="2">BENEFIT DESCRIPTION</th><th rowspan="2">EXPLANATIONS AND LIMITATIONS OF BENEFITS</th><th colspan="2">CHP PPO Plan</th><th colspan="2">CHP EPO Plan</th></tr>
<tr><th>In-Network</th><th>Out-of-Network*</th><th>In-Network</th><th>Out-of-Network*</th></tr>
<tr><td><u>Clinical Trials</u> (Routine Costs Associated with Clinical Trials)

• Coverage is provided for services and supplies for routine patient costs you receive as a participant in an approved clinical trial.
• The services must be those that are listed as covered by this Plan for members who are not enrolled in a clinical trial.
• An “approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated.</td><td>Coverage is limited to the following clinical trials:
1) Federally funded trials approved or funded by one or more of the following:
a. The National Institutes of Health,
b. The Centers for Disease Control and Prevention,
c. The Agency for Health Care Research and Quality,
d. The Centers for Medicare and Medicaid Services,
e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review: The Department of Veterans Affairs, The Department of Defense, or The Department of Energy.
2) Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3) Studies or investigations done for drug trials that are exempt from the investigational new drug application.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an investigative service as defined by the plan. Participation in the clinical trial must be recommended by your physician after determining participation has a meaningful potential to benefit you. Routine patient costs do not include the costs associated with any of the following:
1) The investigational item, device, or service itself.
2) Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
3) Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4) Any item, device, or service that is paid for, or should have been paid for, by the sponsor of the trial.

Note: You will be financially responsible for the costs associated with non-covered services.</td><td>Coverage varies according to the location in which the routine patient care associated with a covered clinical trial is provided.</td><td>Coverage varies according to the location in which the routine patient care associated with a covered clinical trial is provided.</td><td>Coverage varies according to the location in which the routine patient care associated with a covered clinical trial is provided.</td><td>No coverage</td></tr>
</table>

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental) • Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows: • rental (but only up to the allowed purchase price of the device). • purchase of standard model. • repair, adjustment or servicing of the device as is Medically Necessary. • replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired. • An external Hearing Aid is payable one aid per ear every 3 years.	• Corrective Appliances (prosthetic and orthotic devices) are covered only when ordered by a Physician or Health Care Practitioner. • **Prosthetic Devices** are payable when medically necessary including necessary supplies. Prosthetic devices include: • breast prosthesis following a mastectomy (removal of the breast), • a device to restore a method of speaking when required as a result of a covered medically necessary laryngectomy (removal of the larynx that contains the vocal cords), • surgical implants, • artificial limbs or eyes, • the first pair of contact lenses or eyeglasses when required as a result of a covered medically necessary eye surgery, • therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications, • orthopedic footwear used as an integral part of a brace, • shoe inserts that are custom molded to the patient. • **Hearing Services**: The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. 1) Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under plan benefits for office visits to physicians. 2) External hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. 3) Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid. Benefits are provided for **one external hearing aid per ear every three years**. No benefits will be provided for charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than one hearing aid per ear every three years. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices) are payable if medically necessary as a prosthetic device. • See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.	Hearing Exam: No charge, no deductible applies Other services: 90% after deductible met	60% after deductible met	Hearing Exam: No charge, no deductible applies Other services: 80% after deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Dental Services • Under certain circumstance dental care may be payable under this Medical Plan. See the explanations to the right.	**Dental Care** 1) **Admissions for Dental Care.** Listed inpatient hospital services for up to three days during a hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.). The Medical Plan claims administrator will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital stays for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below. 2) **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if (a) the member is less than seven years old, (b) the member is developmentally disabled, or (c) the member's health is compromised and general anesthesia is medically necessary. Charges for the dental procedure itself, including professional fees of a dentist, are not covered. 3) **Accidental Injury To Teeth.** Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to teeth. Coverage payable for services that are medically necessary to repair the damage done by accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to teeth due to chewing or biting is not accidental injury.	Coverage varies according to the location in which the covered service is provided.	Coverage varies according to the location in which the covered service is provided.	Coverage varies according to the location in which the covered service is provided.	No coverage

Diabetes Services
• Diabetes Education Program (DEP) which:
1) 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;
2) 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
3) Is supervised by a physician.
Diabetes education services are covered under the benefits for office visits to physicians.
	• These services and supplies provided for the treatment of diabetes are covered under the benefits for durable medical equipment (see "Durable Medical Equipment"):
	  • Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
	  • Insulin pump.
	  • Pen delivery systems for insulin administration (non-disposable).
	  • Podiatric devices, such as therapeutic shoes and shoe inserts to treat diabetes-related complications.
	  • Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
	• The following items are covered as medical supplies: Insulin syringes, disposable pen delivery systems for insulin administration, testing strips, lancets, and alcohol swabs.
	• Charges for insulin and other prescriptive medications for diabetes treatment are covered under the plan's "Prescription Drug" benefits. Also, certain diabetes-related supplies are also covered under the outpatient prescription drug program. See the Drug row in this Schedule.
	• Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.
		Diabetes Education: 100% after a $20 copay per visit, no deductible applies	Diabetes Education: 60% after deductible met	Diabetes Education: 100% after a $50 copay per visit, no deductible applies	No coverage

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Dialysis • Dialysis for the treatment of acute kidney failure, end-stage kidney disease and chronic renal disease. • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	Coverage varies according to the location in which the covered service is provided.	Coverage varies according to the location in which the covered service is provided.	Coverage varies according to the location in which the covered service is provided.	No coverage

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Drugs (Outpatient Medicines) • Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or Health Care Practitioner authorized by law to prescribe them. • Coverage is also provided for drugs required to be covered due to Health Reform, FDA-approved female contraceptives such as birth control pills/patch, diaphragms, insulin and diabetic blood glucose testing supplies such as lancets, test strips, alcohol swabs, spacer for inhaler and asthma nebulizer tubing. • Contact the Prescription Benefit Manager (PBM) (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following: ◦ The list of drugs on the **Preferred Drug formulary**. ◦ Information on **drugs needing preapproval** by the clinical staff of the Prescription Benefit Manager (PBM) such as compound drugs costing $300 or more. ◦ **Specialty drugs** are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis or rheumatoid arthritis. These drugs often require special handling, and are generally available only in a 34-day quantity. • **Note that if the cost of the drug is less than the copay you pay just the drug cost**. • In accordance with Health Reform, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner. **Please contact the Human Resources Benefits Unit for a full "member friendly" description of your preventive care benefits.** • Drugs not yet approved by the FDA are not covered**. New FDA-approved drugs** will be covered by the Plan unless an amendment states otherwise or the class of drug is excluded.	**No deductible applies to outpatient drugs.** **Out-of-Pocket Limit:** Your copayments for covered outpatient Prescription Drugs accumulate to a Prescription Drug Out-of-Pocket Limit each plan year (June 1 to May 31), then the Plan pays 100% toward covered drugs: **PPO Plan: $1,100 per person; $1,700 per family EPO Plan: $1,100 per person; $1,700 per family** **The Prescription Drug Program:** Benefits for prescription drugs are provided through the Plan's Prescription Benefit Manager (PBM) whose name is listed on the Quick Reference Chart in the front of this document. You pay the lesser of the copayment or the drug cost. • **Retail Drugs**: To obtain up to a **34-day supply** of medicine for the copay noted to the right present your ID card to any In-Network retail pharmacy. Contact the Prescription Benefit Manager (PBM) (whose name is listed on the Quick Reference Chart) for the location of In-Network retail pharmacies. • **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many drugs, plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a **90-day supply** of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Note that not all medicines are available via mail order. Check with the Prescription Benefit Manager (PBM) for further information. To use the mail order service, have your doctor write the prescription for a 90-day supply, with the appropriate refills. Then, mail your prescription, copay and the mail order form to the Mail Order Services of the Prescription Benefit Manager (PBM) whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Benefit Manager (PBM). Allow up to 14 days to receive your order. • **Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. DMR forms may be obtained from the Prescription Drug Program. For eligible prescriptions, you will be reimbursed according to the amount that would have been allowed had you used an In-Network retail pharmacy minus the appropriate copay/coinsurance. • **The Plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless if you or your doctor request it, you will pay the brand copay plus the difference in cost between the generic and brand name drug.** • No coverage for non-prescription male contraceptives, weight management drugs, fertility inducing drugs, growth hormone or over-the-counter (OTC) medications, except certain types of insulin and OTC drugs required due to Health Reform. See also the exclusions related to Drugs (Medicines) in the Exclusions chapter. • CDC recommended immunizations are payable at no cost-sharing at network retail pharmacy locations. • **FDA-approved Contraceptives for females, and Tamoxifen to reduce the risk of breast cancer:** 100%, no cost-sharing for generic drugs submitted with a physician prescription purchased at an In-network Retail or Mail Order location only. No charge for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate.	**In-Network Retail Pharmacy and Specialty Drugs (up to a 34-day supply): Generic:** $5 copay **Preferred Brand:** $20 copay **Non-Preferred Brand** $40 copay **Female contra-ceptives and Tamoxifen:** No charge. **Mail Order Service (up to a 90-day supply): Generic:** $10 copay **Preferred Brand:** $40 copay **Non-Preferred Brand:** $80 copay	**Use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network retail pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimburse-ment (DMR) process as described to the left.	**In-Network Retail Pharmacy and Specialty Drugs (up to a 34-day supply): Generic:** $10 copay **Preferred Brand:** $35 copay **Non-Preferred Brand** $70 copay **Female contra-ceptives and Tamoxifen:** No charge. **Mail Order Service (up to a 90-day supply): Generic:** $20 copay **Preferred Brand:** $70 copay **Non-Preferred Brand:** $140 copay	**Use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network retail pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimburse-ment (DMR) process as described to the left.

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*

Durable Medical Equipment (DME)
• Coverage is provided for:
  • 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 (but not disposable);
    2) For the exclusive use of the patient;
    3) Not primarily for comfort or hygiene;
    4) Not for environmental control or for exercise; and
    5) Manufactured specifically for medical use.
  The Medical Plan claims administrator will determine whether the item satisfies the conditions above.
• Hearing aids (see the Corrective Appliance row).
• Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration; related respiratory therapy supplies.
• Colostomy, ostomy and/or urinary catheter supplies.
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter.
	• Durable Medical Equipment (and supplies necessary for the function of the durable medical equipment) is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner.
	• **Pediatric Asthma Equipment and Supplies**: The following items and services when required for the medically necessary treatment of asthma in a dependent child:
	  1) Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the plan's medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
	  2) Education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the plan's benefits for office visits to a physician.
	• For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus the breast pump supplies necessary to operate the breast pump. Coverage is provided for one breast pump per covered pregnancy.
	• **Diabetes Services:** These services and supplies provided for the treatment of diabetes are covered under the benefits for durable medical equipment (see "Durable Medical Equipment"):
	  • Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
	  • Insulin pump.
	  • Pen delivery systems for insulin administration (non-disposable).
	  • Podiatric devices, such as therapeutic shoes and shoe inserts to treat diabetes-related complications.
	  • Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter.
		Breast pump: No charge
		
		All other DME: After deductible met Plan pays 90%
			Breast Pump: After deductible met Plan pays 60%
			
			All other DME: After deductible met Plan pays 60%
				Breast pump: No charge
				
				All other DME: After deductible met Plan pays 80%
					No coverage

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
<u>**Emergency Room Facility and Urgent Care Facility**</u> • **Hospital emergency room (ER) facility** for a medical Emergency (as the term "Emergency services" is defined in this Plan). • **Urgent Care facility.** Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections. • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• **Emergency room facility copayment** will be waived if a subsequent immediate hospitalization is required. • There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. • Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with health reform Affordable Care Act regulations. See the definition of Maximum Allowed Amount or contact the Medical Plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers. • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	**Emergency Room Facility fees**: You pay a $100 copay per visit then Plan pays balance at 90% after the deductible is met. **Urgent Care Facility fees**: You pay a $20 copay per visit, no deductible, then Plan pays balance	**Emergency Room Facility fees**: For an Emergency situation, you pay a $100 copay per visit then Plan pays balance at 90% after the deductible is met. For a non-emergency, the Plan pays 60% after the deductible is met. **Urgent Care Facility fees**: After deductible met Plan pays 60%.	**Emergency Room Facility fees**: You pay a $150 copay per visit then Plan pays balance at 80% after the deductible is met. **Urgent Care Facility fees**: You pay a $50 copay per visit, no deductible, then Plan pays balance.	**Emergency Room Facility fees**: For an Emergency situation, you pay a $150 copay per visit then Plan pays balance at 80% after the deductible is met. Non-emergency is not covered. **Urgent Care Facility fees**: No coverage.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
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<table>
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<tr><th>In-Network</th><th>Out-of-Network*</th><th>In-Network</th><th>Out-of-Network*</th></tr>
<tr><td><u>Family Planning, Reproductive, Contraceptive Fertility Services</u>
• Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). There is no cost-sharing for female sterilization when performed by in-network providers.
• Services and supplies provided in connection with the following methods of FDA-approved contraception:
◦ Injectable drugs and implants for birth control, administered in a physician's office, if medically necessary.
◦ Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a physician if medically necessary.
◦ Professional services of a physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.
◦ If your physician determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your physician.
◦ See also the Drug row of this Schedule for information on prescription FDA-approved contraceptive coverage.
• Fertility and infertility services includes only evaluation (diagnosis) and surgical repair.</td><td>• For maternity coverage see the Maternity row in this schedule.
• Certain contraceptives are available through the Prescription Drug Program (see the Drugs row of this Schedule).
• No coverage for reversal of sterilization procedures.
• No coverage for fertility services (other than diagnosis and surgical repair) that induce pregnancy, including but not limited to, surgical impregnation procedures like fertility drugs, artificial insemination or invitro fertilization. See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; and Maternity Services in the Exclusions chapter.
• These services are covered: Elective induced abortion and Prescription Drug for Abortion: Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.</td><td>Female Contra-ceptives and Female sterilization procedures: 100% no deductible.

For other services, see the Physician services row of this Schedule.</td><td>Female Contra-ceptives and Female sterilization procedures: After deductible met Plan pays 60%

For other services, see the Physician services row of this Schedule.</td><td>Female Contra-ceptives and Female sterilization procedures: 100% no deductible.

For other services, see the Physician services row of this Schedule.</td><td>No coverage</td></tr>
<tr><td><u>Foods: Special Food Products/Formula for Treatment of Phenylketonuria</u></td><td>• Special food products and formulas that are part of a diet prescribed by a Physician for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.</td><td>After deductible met, Plan pays 90%</td><td>After deductible met, Plan pays 60%</td><td>After deductible met, Plan pays 80%</td><td>No coverage</td></tr>
</table>

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Gene Therapy • Gene therapy seeks to modify or introduce genes into a patient's body with the goal of treating, preventing or potentially curing a disease. • The Plan covers medically necessary non-experimental, FDA-approved gene therapy treatment when precertification is obtained. See also the definition of Gene Therapy in the Definitions chapter.	• **Gene therapy services require precertification** (to avoid non-payment) by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. • The Plan does not cover: - Services determined to be Experimental/Investigational; - Services provided by a non-approved Provider or at a non-approved Facility; or - Services not approved in advance by precertification.	Payment varies by location in which gene therapy is delivered.	Payment varies by location in which gene therapy is delivered.	Payment varies by location in which gene therapy is delivered.	No coverage
Hearing Aid	• See the Corrective Appliance row in this Schedule.				
Home Health Care and Home Infusion Therapy Services **For the PPO Plan only:** the following services provided by a home health agency: 1) Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician. 2) Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy. 3) Services of a medical social service worker. 4) Services of a home health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1) or 2) above. 5) Medically necessary supplies provided by a home health agency.	• **EPO Plan: no coverage for home health care**. • **PPO Plan**: Home health and home infusion therapy services must be ordered by a Physician. See also the definition of Infusion Therapy in the Definitions chapter. **Home Health Care is limited to 100 visits per Plan year.** • **PPO Plan: Home health and home infusion therapy services require precertification** by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter. The Physician's treatment plan will be reviewed to determine the necessity of continued home health and home infusion therapy services. Home health care services are not covered if received while you are receiving benefits under the "Hospice" provision. 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); but 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 of durable medical equipment is covered under "Durable Medical Equipment"; 5) Laboratory services to monitor the patient's response to therapy regimen. • See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • Home Hospice services are payable under Hospice benefits.	After deductible met, Plan pays 90%	After deductible met, Plan pays 60%	Home Infusion Therapy: 80% after deductible met Home Health Care: No coverage	No coverage

SCHEDULE OF MEDICAL BENEFITS

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of hospice in the Definitions chapter of this document.	• Covered only when ordered by a Physician. Your physician must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must submit a written treatment plan to the Medical Plan claims administrator every 30 days	90% after deductible met	60% after deductible met	80% after deductible met	No coverage
Laboratory Services (Outpatient) • Common Laboratory services include diagnostic testing related to chemistry, hematology, urinalysis, toxicology, microbiology, blood banking, anatomic pathology–surgical pathology and/or cytopathology. Specialty reference laboratory services can include gene-based and molecular testing, allergy testing, transplant matching, tumor tissue analysis, infectious disease testing, etc. • Technical and professional fees.	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Wellness benefits in this Schedule, such as cholesterol screening, blood lead level screening for children, etc.	90% after deductible met	60% after deductible met	80% after deductible met	No coverage

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Certified Nurse Midwife fees for Medically Necessary maternity services. • See the Family Planning row and Drug row for information on contraceptive coverage. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren). • When benefits for pregnancy or maternity care are payable (note exception to the right for dependent child), they include: 1) Prenatal and postnatal care; 2) Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other medically necessary maternity services performed outside of a hospital); 3) Involuntary complications of pregnancy; 4) Diagnosis of genetic disorders in cases of high-risk pregnancy; and 5) Inpatient hospital care including labor and delivery. 6) Certain services are covered under the “Preventive Care Services” benefit. • Breast pump payable as noted on the Durable Medical Equipment row of this Schedule. • The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider while breastfeeding, at 100%, no deductible, when provided by an in-network provider. • See also the Family Planning row.	• Pregnancy-related care is covered for a female Employee, Retiree, Spouse or Domestic Partner only. **The Plan does not pay for expenses related to certain non-office visit/non-health reform mandated maternity care and delivery expenses associated with a pregnant dependent child.** This exclusion of maternity care for a pregnant dependent child applies to maternity services that are not office visits and are not mandated by health reform, such as ultrasounds and delivery expenses. • Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, blood pressure screening for all pregnant women throughout pregnancy to identify preeclampsia, screening for gestational diabetes, HPV testing starting at age 30, rental of breastfeeding equipment and necessary supplies after delivery, and in conjunction with birth, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period). These services are covered without cost sharing for a female when obtained from in-network providers. • For all females, prenatal and postnatal office visits obtained from an in-network provider are payable at no cost to you. • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. **For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Member Services to precertify the extended stay.** Refer to the Utilization Review chapter in this document for information on precertification. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. • See the exclusions related to Maternity Services in the Exclusions chapter.	Prenatal and postnatal office visits and health reform mandated services: 100%, no deductible or copay. Breast-pump: 100% no deductible. Lactation counseling: 100%, no deductible. For Delivery fees: refer to physician and hospital rows of this schedule. All other services including ultrasounds and professional delivery fees: 90% after deductible met.	After deductible met Plan pays 60%.	Prenatal and postnatal office visits and health reform mandated services: 100%, no deductible or copay. Breast pump: 100% no deductible. Lactation counseling: 100%, no deductible. For Delivery fees: refer to physician and hospital rows of this schedule. All other services including ultrasounds and professional delivery fees: 80% after deductible met.	No coverage

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		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Mental Health and Substance Abuse Treatment	• See the Behavioral Health row in this Schedule.				
Nondurable Medical Supplies • Coverage is provided for Medically Necessary nondurable supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	90% after deductible met	60% after deductible met	80% after deductible met	No coverage
Oral, Craniofacial Services • Accidental Injury to Teeth/Jaw (see the Dental row of this Schedule) • Medically Necessary Oral and/or Craniofacial Surgery.	• No coverage for dental services such as removal of teeth including wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement) or treatment of temporomandibular joint (TMJ) syndrome/dysfunction. • See also the exclusions related to Dental Services in the Exclusions chapter.	Physician services payable according to the Physician services row of this Schedule.	Physician services payable according to the Physician services row of this Schedule.	Physician services payable according to the Physician services row of this Schedule.	Physician services payable according to the Physician services row of this Schedule.
Outpatient (Ambulatory) Surgery Facility/Center • Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery, outpatient surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.		**Facility fees:** After deductible met Plan pays 90% Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	**Facility fees:** After deductible met Plan pays 60% Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	**Out-patient Surgery Facility fees:** After deductible met and you pay a $500 copay then Plan pays 80% Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	No coverage

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*

Pervasive Developmental Disorder or Autism
• This plan provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions, except as specifically stated in this section.
• Behavioral health treatment services covered under this plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions.
• Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" to the right) will be covered under plan benefits for office visits to physicians, whether services are provided in the provider's office or in the patient's home.
• Services provided in a facility, such as the outpatient department of a hospital, will be covered under plan benefits that apply to such facilities.
• See the next row in this Schedule for definitions related to coverage for behavioral health treatment for Pervasive Developmental Disorder or autism.
	• The behavioral health treatment services covered by this plan for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:
	  • The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
	  • The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
	  • The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
	    a. Describes the patient's behavioral health impairments to be treated,
	    b. Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
	    c. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
	    d. Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
	    e. The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to the Medical Plan Claims Administrator upon request.
	• **See the next row** in this Schedule for definitions related to coverage for behavioral health treatment for Pervasive Developmental Disorder or autism.
		Office Visit: $20 copay per visit, no deductible
		
		Other outpatient services: After deductible met Plan pays 90%
			Office Visit, Other outpatient services: After deductible met Plan pays 60%	Office Visit: $50 copay per visit, no deductible
				
				Other outpatient services: After deductible met Plan pays 80%
					No coverage

SCHEDULE OF MEDICAL BENEFITS

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<tr><td><u>Pervasive Developmental Disorder or Autism</u>

See the row above in this Schedule for more information related to coverage for behavioral health treatment for Pervasive Developmental Disorder or autism.</td><td>• Key Definitions below:
• Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.
• Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.
• Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.
• Qualified Autism Service Provider is either of the following:
a. A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
b. A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.
The Medical Plan claims administrator's network of participating providers is limited to licensed Qualified Autism Service Providers who contract with the network and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.
• Qualified Autism Service Professional is a provider who meets all of the following requirements:
a. Provides behavioral health treatment,
b. Is employed and supervised by a Qualified Autism Service Provider,
c. Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
d. Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
e. Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.
• Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:
a. Is employed and supervised by a Qualified Autism Service Provider,
b. Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
c. Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, &
d. Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.</td><td colspan="4">See the row above in this Schedule for more information related to coverage for behavioral health treatment for Pervasive Developmental Disorder or autism.</td></tr>
</table>

SCHEDULE OF MEDICAL BENEFITS

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		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Prescription Drugs (Outpatient)	• See the Drug row for information on outpatient retail and mail order prescription medication.				
Prosthetic Devices	• See the Corrective Appliances row in this Schedule.				
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. • Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • **Certain imaging procedures require precertification**, 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, by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter. • Some Radiology procedures are covered under the Wellness Programs described in this Schedule.	After deductible met Plan pays 90%	After deductible met Plan pays 60%	After deductible met Plan pays 80%	No coverage

Reconstructive Services and Breast Reconstruction After Mastectomy
• Reconstructive surgery is payable when 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.
	• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
	  • reconstruction of the breast on which the mastectomy was performed;
	  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
	  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter.
		See the Hospital, Outpatient Surgery and Physician services rows of this Schedule.	See the Hospital, Outpatient Surgery and Physician services rows of this Schedule.	See the Hospital, Outpatient Surgery and Physician services rows of this Schedule.	No coverage

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		In-Network	Out-of-Network*	In-Network	Out-of-Network*

<u>Rehabilitation Services (Physical, Occupational, Speech Therapy and Cardiac Rehabilitation)</u>
• Short term **<u>active</u>, <u>progressive</u>** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician.
• **Chiropractic services**.
• Inpatient Rehabilitation Services are covered when precertified**.**
	• **Inpatient Rehabilitation admission requires precertification** by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter for details.
	• Rehabilitation services are covered only when ordered by a Physician. The following services provided by a Physician under a treatment plan:
	  ◦ **Physical therapy**, physical medicine and chiropractic services 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 that are customarily provided by chiropractors, physical therapists and osteopaths.) Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.
	  ◦ **Occupational therapy**: under the PPO Plan and EPO Plan occupational therapy is only covered when provided by a home health agency, hospice or home infusion therapy provider.
	  ◦ **Speech Therapy Services:** Outpatient charges of a qualified speech therapist for correction of a speech impediment incurred if caused by sickness or injury or due to surgery because of illness.
	  ◦ **Cardiac rehabilitation and Habilitation services**.
	• 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.
		Outpatient visits: After deductible met Plan pays 90%
		
		Inpatient Rehab admission: See the hospital services row of this Schedule
			Outpatient visits: After deductible met Plan pays 60%
			
			Inpatient Rehab admission: See the hospital services row of this Schedule
				Outpatient visits: After deductible met Plan pays 80%
				
				Inpatient Rehab admission: See the hospital services row of this Schedule
					No coverage

<u>Residential Treatment Program</u>	• See the Behavioral Health row in this Schedule.				
<u>Skilled Nursing Facility (SNF) or Subacute Facility</u> • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility.	• **Admission to a Skilled Nursing Facility (SNF) or Subacute facility requires precertification** by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter for details. • Services must be ordered by a Physician. To determine if a facility is a skilled nursing facility or subacute facility/long term acute care facility, see the Definitions chapter of this document. • **PPO Plan:** Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to **100 days per plan year.** The amount by which your room charge exceeds the prevailing two-bed room rate of the skilled nursing facility is not considered a covered expense.	Facility fees: After deductible met Plan pays 90%	Facility fees: After deductible met Plan pays 60%	No coverage	No coverage
<u>Substance Abuse/Substance Use Treatment</u>	• See the Behavioral Health services row in this Schedule.				

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental non-investigative transplants of human organs or tissue including (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures), along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • If you are the recipient, an organ or tissue donor who is not an enrolled member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. • The plan's payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed **$30,000** per transplant. • Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.	• **All Transplant services including pre-transplant workup tests require precertification** by calling Member Services whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter for details. The transplant surgeons and facility must also be approved for the requested transplant. • **Services for specified transplants <u>are not covered</u> when performed at <u>other than</u> a designated Centers of Medical Excellence (CME).** Contact the Anthem case manager transplant coordinator for the list of designated Centers of Medical Excellence. • **Transplant Travel Expense:** Certain travel expenses are covered when incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated Center of Medical Excellence (CME) that is 75 miles or more from the recipient's or donor's place of residence, provided the expenses are precertified in advance. The plan's maximum payment will not exceed **$10,000** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor (*Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.): 1) Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence. 2) Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's residence. 3) Lodging, limited to one room, double occupancy. 4) Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses, are excluded. The Plan Year Deductible will not apply and no cost-sharing will be required for transplant travel expenses authorized in advance by the Medical Plan Claims Administrator. The plan will provide benefits for lodging and ground transportation up to the current limits set forth in the Internal Revenue Code. Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located. Details regarding reimbursement can be obtained by calling Member Services on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement. • For plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. • See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter.	See the Hospital and Physician services rows in this Schedule for payment details	Services for specified transplants <u>are not covered</u> when performed at other than a designated Center of Medical Excellence. See the Hospital and Physician services rows in this Schedule for payment details	See the Hospital and Physician services rows in this Schedule for payment details	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*

<u>Weight Management</u>
 	
• **Treatment for morbid obesity is covered only when precertified** (meaning that specific criteria are met as recommended by the Medical Plan's claims administrator's Medical Policy).
	• **Bariatric Surgery (weight loss treatment for morbid obesity) requires precertification** by calling the Medical Plan Claim Administrator, whose contact information is listed on the Quick Reference Chart in the front of this document. See also the Utilization Review chapter for details.
	• **Services for bariatric surgery <u>are not covered</u> when performed at other than a designated Centers of Medical Excellence (CME).** Contact the Medical Plan Claim Administrator for the list of designated Centers of Medical Excellence.
	• The in-network coinsurance applies to bariatric surgical procedures determined to be medically necessary by the Medical Plan Claim Administrator when performed at a designated Center of Medical Excellence**.**
	• Coinsurance does not apply to bariatric travel expenses authorized by the Medical Plan claims administrator.
	• **Bariatric travel expense** coverage is available when the closest CME is 50 miles or more from the member's residence (as determined by the Medical Plan Claim Administrator). **All travel expenses must be approved by the Medical Plan Claim Administrator in advance**.
	  ◦ For the member (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit). The plan pays for the member, for transportation to the Center of Medical Excellence, up to $130 per trip.
	  ◦ For the companion (limited to two (2) trips – the initial surgery and one follow-up visit), for transportation to the Center of Medical Excellence, up to $130 per trip.
	  ◦ For the member and one companion (for the pre-surgical visit and the follow-up visit), for Hotel accommodations, up to $100 per day, for up to 2 days per trip, limited to one room, double occupancy.
	  ◦ For one companion (for the duration of the member's initial surgery stay) for Hotel accommodations up to $100 per day, for up to 4 days, limited to one room, double occupancy.
	  ◦ For other reasonable expenses (excluding, tobacco, alcohol, drug, and meal expenses) up to $25 per day, for up to 4 days per trip.
	  ◦ Details regarding reimbursement can be obtained by calling the Medical Plan Member Services 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.
		See the Hospital and Physician services rows in this Schedule for payment details	Services for bariatric services <u>are not covered</u> when performed at other than a designated Center of Medical Excellence.
			
			See the Hospital and Physician services rows in this Schedule for payment details
				See the Hospital and Physician services rows in this Schedule for payment details	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Wellness (Preventive) Program Well Child Examinations and Immunizations • The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations as outlined to the right. Covered services include, but are not limited to: • **Outpatient newborn and well child visits, and routine childhood immunizations** that are FDA approved and in accordance with the Centers for Disease Control (CDC) recommendations for children in the US, such as DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus, influenza (flu) vaccine, HPV (e.g. Gardasil, Cervarix), etc. • Other immunizations for children at high risk are covered under the regular medical plan benefits. • **Immunizations/Vaccinations Available from the Retail Pharmacy**: The Plan covers immunizations recommended by both Health Reform regulations and in accordance with the Centers for Disease Control (CDC). There is no cost-sharing when these are obtained from an in-network retail pharmacy or during an in-network physician office visit. • When performed in primary practices, **topical fluoride** varnish to the primary teeth of children is payable through age 5 years. • For children age 6 years and older with obesity, Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • See the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. **Please contact the Human Resources Benefits Unit for a full "member friendly" description of your preventive care benefits.**	• The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/, and https://www.ahrq.gov, https://www.uspreventiveservicestaskforce.org/. In addition to the wellness services listed on these websites, the Plan will pay for these wellness services: well child office visits, eye exam when obtained during a well child office visit, well woman office visits, screening and counseling for interpersonal and domestic violence, contraceptives, and certain over the counter drugs. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible/copay/coinsurance. • Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. • If there is no network a provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • Preventive services are payable without regard to gender assigned at birth, or current gender status.	100%, no deductible applies	60%, after deductible met	100%, no deductible applies	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted.
***IMPORTANT:** Under the PPO Plan, Out-of-Network providers are paid according to the Maximum Allowed Amount, as defined in the Definitions chapter, and could result in balance billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	CHP PPO Plan		CHP EPO Plan	
		In-Network	Out-of-Network*	In-Network	Out-of-Network*
Wellness (Preventive) Program: Adult Health Maintenance Examinations (Age 18 & up) • The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations as outlined to the right. Covered services include, but are not limited to: • **Adult immunizations** that are FDA approved and in accordance with the Centers for Disease Control (CDC) recommendations for adults in the US, such as annual flu shot, HPV vaccine (e.g. Gardasil, Cervarix), shingles vaccine, etc. • **Immunizations/Vaccinations Available from the Retail Pharmacy**: The Plan covers immunizations recommended by both Health Reform regulations and in accordance with the Centers for Disease Control (CDC). There is no cost-sharing when these are obtained from an in-network retail pharmacy or during an in-network physician office visit. • **Colon cancer screening** is payable for adults age 50 and older. • If a provider orders lab or x-rays tests in addition to and at the same time as what is covered in accordance with health reform preventive care expenses, benefits for the non-health reform related tests will be paid at the Plan's usual payment level for non-wellness/preventive lab and radiology services. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: For adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to **intensive behavioral counseling interventions** to promote a healthful diet and physical activity for CVD prevention. **Please contact the Human Resources Benefits Unit for a full "member friendly" description of your preventive care benefits.**	The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, https://www.uspreventiveservicestaskforce.org/ and https://www.ahrq.gov, http://www.hrsa.gov/womensguidelines/. In addition to the wellness services listed on these websites, the Plan will pay for these wellness services: a wellness/physical exam for adults once each 12 months, well woman office visits, annual prostatic specific antigen (PSA) lab test for men age 40 and older, screening mammogram for women age 18 and older, and osteoporosis screening for women at risk. • In accordance with Health Reform, certain additional preventive care expenses are payable for all covered females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, screening for gestational diabetes, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, breastfeeding equipment and necessary supplies while breastfeeding, lactation support while breastfeeding). These services are covered for females under the Wellness/Preventive Services category without cost sharing when obtained from in-network providers. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. Preventive services are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the individual has a condition or an active symptom of a condition. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine if a service is considered preventive. • If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible/copay/coinsurance. Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • If there is no network provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing.	100%, no deductible applies	60%, after deductible met	100%, no deductible applies	No coverage

MEDICAL NETWORKS

IN-NETWORK AND OUT-OF-NETWORK SERVICES: Plan Participants may obtain health care services from In-Network or Out-of-Network Health Care Providers. But the amount that you pay for such services may vary.

Because Health Care Providers are added to and deleted from networks during the year you should call the network or ask the provider to verify their contracted network status before you visit that provider to assure you will be able to receive their discounted price for the services you need.

- **IN-NETWORK SERVICES:** In-Network Health Care Providers (also called Participating Providers) have agreements with the Plan's Preferred Provider Organization (PPO) and/or Exclusive Provider Organization (EPO) under which they provide health care services and supplies for a favorable negotiated discount fee for PPO or EPO plan participants. When a plan participant uses the services of an In-Network Health Care Provider, the Plan participant is responsible for paying the applicable cost-sharing (cost-sharing being deductible, copayment or coinsurance on the discounted fees) for any Medically Necessary services or supplies, subject to the Plan's limitations and exclusions. **Your lowest out-of-pocket costs occur when you use an in-network provider.**

  For the EPO plan, all care must be provided, or coordinated by, a participating provider physician. Benefits for non-participating providers are provided under the Plan only if you have an authorized referral, for an emergency or for urgent care.

  Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan and where to send their bills.

  The In-Network Health Care Provider generally deals with the Plan directly for any additional amount due.

  IMPORTANT NOTE
  Because providers are added to and dropped from the PPO or EPO network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the PPO or EPO or contact the network each time BEFORE you seek services.
  For a list of In-Network providers, see the website of the PPO Network or EPO Network located on the Quick Reference Chart in the front of this document.

  You may also verify if your Health Care Provider is an In-Network provider by contacting the PPO or EPO network at their phone number and website listed on the Quick Reference Chart in the front of this document.

- **OUT-OF-NETWORK SERVICES:** Out-of-Network Health Care Providers (also called Non-Network, non-PPO, non-EPO and Non-participating providers) have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan participant for the Maximum Allowed Amount (as defined in this document) for any Medically Necessary services or supplies, subject to the Plan's deductibles, coinsurance (on non-discounted services), copayments limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made.
  - **CAUTION: Out-of-Network Health Care Providers may bill you for any balance that may be due in addition to the Maximum Allowed Amount payable by the Plan, also called balance billing.** Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using In-Network providers.** (See the definitions of Maximum Allowed Amount and Balance Billing in the Definitions chapter of this document.)
  - **For the EPO plan**, all care must be provided, or coordinated by, a participating provider physician. Benefits for non-participating providers are provided under the Plan only if you have an authorized referral, for an emergency or for urgent care.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The PPO and EPO medical plans in this document **do not** require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or Non-Network health care provider; however, payment by the Plan may be less for the use of a Non-Network provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or

gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website listed on the Quick Reference Chart.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan's Preferred Provider Organization (PPO) is a network of Hospitals, Physicians, laboratories and other Health Care Providers who are located within a Service Area and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to PPO Plan participants.

If you receive Medically Necessary services or supplies from a PPO Provider you will commonly have less money to pay, less cost-sharing with deductibles, copayment and coinsurance, than if you received those Medically Necessary services or supplies from a Health Care Provider who is not a PPO Provider, **and** the PPO Provider has agreed to accept the Plan's payment plus any applicable Deductible, Copayment or Coinsurance that you are responsible for paying as payment in full.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

The Plan's Exclusive Provider Organization (EPO) is a network of participating providers like Hospitals, Physicians, medical laboratories and other Health Care Providers who are located within a Service Area and who have agreed to provide Medically Necessary services and supplies for favorable negotiated discount fees applicable only to EPO Plan participants.

- **Under the EPO Plan there is coverage ONLY when you use an EPO provider**.
- **The only exception is if you are traveling outside the EPO service area and you have an emergency or need urgent care or your EPO physician has an authorized referral to a non-EPO provider.** In the case of an emergency, you should use the nearest emergency room (ER) and later, send your claims to the EPO Claims Administrator who will pay the emergency services according to how EPO provider claims are paid.

SERVICE AREA: A **"Service Area"** is a geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPO and/or EPO.

Before you obtain services or supplies from an Out-of-Network Health Care Provider, you can find out whether the Plan will provide In-Network or Out-of-Network Benefits for those services or supplies by contacting the PPO network, EPO network or Medical Plan Claims Administrator at their phone number and website shown on the Quick Reference Chart in the front of this document.

WRAP NETWORK(S) FOR THE PPO PLAN PARTICIPANTS

Note that while there is a primary network of Preferred PPO providers within the state of California, for those plan participants that reside outside the state of California, the Plan has contracted with one or more additional PPO networks. These additional PPO networks that exist outside the state of California are sometimes called "wrap" networks. On your medical plan ID card, you may notice the logo for these wrap networks that helps identify the participant as a person who can access the discounts from the wrap network. The wrap networks pertain to PPO plan participants.

DIRECTORIES OF NETWORK PROVIDERS

There is no cost to you for access to the PPO or EPO provider directory. See the website of the PPO Network or EPO Network (listed on the Quick Reference chart in the front of this document).

Physicians and Health Care Providers who participate in the Plan's Networks are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the Network by contacting the PPO network or EPO network at their telephone number or website (to access their free provider network directory) shown on the Quick Reference Chart in the front of this document.

> **Remember,** because providers are added to and dropped from the PPO and/or EPO network periodically throughout the year **it is best if you ask your Health Care Provider IF they are still participating with the PPO or EPO, or contact the appropriate PPO network or EPO network each time BEFORE you seek services.**

INTER-PLAN ARRANGEMENTS

Out-of-Area Services

Overview. The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services

outside the geographic area we serve (the "Anthem Blue Cross" Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Blue Cross Service Area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") do not contract with the Host Blue. See below for an explanation of how both kinds of providers are paid.

For EPO plan, Anthem Blue Cross covers only limited healthcare services received outside of the Anthem Blue Cross Service Area. For example, emergency or urgent care obtained outside the Anthem Blue Cross Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem Blue Cross.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, the claims administrator will still fulfill the plan's contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem Blue Cross Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to the claims administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account special arrangements with that provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem Blue Cross may process your claims for covered services through Negotiated Arrangements for National Accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem Blue Cross by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program: If you receive covered services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem Blue Cross through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements: If Anthem Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the group on your behalf, Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Non-participating Providers Outside Our Service Area

1. **Allowed Amounts and Member Liability Calculation**.

   When covered services are provided outside of Anthem Blue Cross's Service Area by non-participating providers, the claims administrator may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or co-payment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the claims administrator will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions**.

   In certain situations, the claims administrator may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the covered services as set forth in this paragraph.

F. BlueCross BlueShield Global Core® Program

If you plan to travel outside the United States, call Member Services for information about your BlueCross BlueShield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The EPO Plan only covers emergency, including ambulance, and urgent care outside of the United States. Remember to take an up to date health ID card with you.

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

If you need inpatient hospital care, you or someone on your behalf, should contact the claims administrator for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Utilization Review Program" section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the hospital for emergency or non-emergency care.

How Claims are Paid with BlueCross BlueShield Global Core

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

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

- Physician services;
- Inpatient hospital care not arranged through BlueCross BlueShield Global Core; and
- Outpatient services.

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

When you need BlueCross BlueShield Global Core claim forms you can get international claims forms in the following ways:

- Call the BlueCross BlueShield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com

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

B. CARE OUTSIDE THE UNITED STATES—BlueCross BlueShield Global Core

Prior to travel outside the United States, call the Member Services telephone number listed on your ID card to find out if your plan has BlueCross BlueShield Global Core benefits. Your coverage outside the United States is limited and it is recommended that:

- Before you leave home, call the Member Services number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with urgent care or an emergency when travelling outside the United States.**
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.

The BlueCross BlueShield Global Core Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

Payment Information:

- **Participating BlueCross BlueShield Global Core hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCross BlueShield Global Core hospitals except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The hospital should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a physician, and inpatient care from a hospital that is not a participating BlueCross BlueShield Global Core hospital. Then you can complete a BlueCross BlueShield Global Core claim form and send it with the original bill(s) to the **BlueCross BlueShield Global Core** Service Center (the address is on the form).

Claim Filing:

Participating BlueCross BlueShield Global Core hospitals will file your claim on your behalf. You will have to pay the hospital for the out-of-pocket costs you normally pay. **You must file the claim** for outpatient and physician care, or inpatient hospital care not provided by a participating BlueCross BlueShield Global Core hospital. You will need to pay the health care provider and subsequently send an international claim form with the original bills to the claims administrator.

Additional Information About BlueCross BlueShield Global Core Claims:

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.
- Exchange rates are determined as follows:
  - For inpatient hospital care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms: International claim forms are available from the claims administrator, from the BlueCross BlueShield Global Core Service Center, or online at: **Error! Hyperlink reference not valid.** The address for submitting claims is on the form.

See also the General Provisions chapter of this document for more BlueCard information.

UTILIZATION REVIEW (UR) PROGRAM

Purpose of the Utilization Review (UR) Program: Your plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the County to afford the cost of maintaining your plan.

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Utilization Review Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the County is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Review Program, you may avoid some Out-of-Pocket costs. However, if you don't follow these procedures, your plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

Your plan includes the process of utilization review to decide when services are medically necessary or experimental / investigative as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be medically necessary to be a covered service.

When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be medically necessary if they are given in a higher level of care, or higher cost setting / place of care.

Certain services must be reviewed to determine medical necessity in order for you to get benefits. Utilization review criteria will be based on many sources including medical policy and clinical guidelines. The claims administrator may decide that a service that was asked for is not medically necessary if you have not tried other treatments that are more cost-effective.

If you have any questions about the information in this section, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. The service or supply must be a covered service under your plan;
3. The service cannot be subject to an exclusion under your plan (please see MEDICAL CARE THAT IS NOT COVERED for more information); and
4. You must not have exceeded any applicable limits under your plan.

TYPES OF REVIEWS

- **Pre-service Review –** A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.

  Precertification – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is experimental / investigative as those terms are defined in this booklet.

  For admissions following an emergency, you, your authorized representative or physician must tell the claims administrator within 24 hours of the admission or as soon as possible within a reasonable period of time.

  For childbirth admissions, precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

  For inpatient hospital stays for mastectomy surgery, including the length of hospital stays associated with mastectomy, precertification is not needed.

- **Continued Stay / Concurrent Review –** A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that

cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the plan has a related clinical coverage guideline and are typically initiated by the claims administrator.

Services for which precertification is required (i.e., services that need to be reviewed by the claims administrator to determine whether they are medically necessary) include, but are not limited to, the following:

When the following services are planned or obtained from a NON-NETWORK provider then YOU MUST PRECERTIFY the service BEFORE the services are provided.

SERVICES THAT MUST BE PRECERTIFIED BY CONTACTING THE MEDICAL PLAN CLAIMS ADMINISTRATOR:

1. **All inpatient hospital admissions and residential treatment center admissions**.

   (*Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section. Utilization review is not required for inpatient hospital stays for Mastectomy and lymph node dissection.)*
2. **Transplant services**: an upcoming transplant as soon as the participant is identified as a potential transplant candidate.
3. **Home Health Care and Home Infusion Therapy Services**.
4. Admission to a **Skilled Nursing Facility**.
5. **Bariatric surgical services** performed at a Centers of Medical Excellence (CME) facility.
6. **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 sca**n), Magnetic Resonance Angiogram (**MRA scan**), and **nuclear cardiac imaging**.
7. Any technique that uses genes to treat or prevent disease (**gene therapy**) including, but not limited to Yescarta, Kymriah, Luxturna, or Zolgensma.

Precertification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

PLEASE CONTACT THE MEDICAL PLAN CLAIMS ADMINISTRATOR FOR ASSISTANCE COORDINATING THESE SERVICES:

1. Behavioral health services for the treatment of Pervasive Developmental Disorder or autism.
2. Medical or surgical treatment of gender dysphoria.

SERVICES THAT MUST BE PRECERTIFIED BY CONTACTING THE PRESCRIPTION DRUG PROGRAM (whose contact information is listed on the Quick Reference Chart in the front of this document):

1. **Certain medications require precertification** by contacting the Prescription Drug Program, whose contact information is listed on the Quick Reference Chart in the front of this document.

Prior notification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

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 or residential treatment center admission, or for facility-based care for the treatment of a mental health and substance abuse condition, the benefits to which you would have been otherwise entitled will be subject to the "Failure to Follow Required Utilization Review" shown in this chapter.
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:

Transplant services as follows:

a. For 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 heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell 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.

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.

Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:

a. The services are to be performed for the treatment of morbid obesity;

b. The physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

c. The bariatric surgical procedure will be performed at a CME facility.

Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

Behavioral health treatment for pervasive developmental disorder or autism, as specified in that row of the Schedule of Medical Benefits.

For a list of current procedures requiring precertification, please call the toll-free number for Member Services printed on your Identification Card.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

Typically, participating providers know which services need precertification and will get any precertification when needed. Your physician and other participating providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, hospital or attending physician ("requesting provider") will get in touch with the claims administrator to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Participating Providers	Provider	The provider must get precertification when required.
Non-Participating Providers	Member	Member must get precertification when required. (Call Member Services.) Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be medically necessary.

Blue Card Provider	Member **(except for Inpatient Admissions)**	Member must get precertification when required. (Call Member Services.) Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be medically necessary. **Blue Card Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an emergency admission, precertification is not required. However, you, your authorized representative or physician must notify the claims administrator within 24 hours of the admission or as soon as possible within a reasonable period of time.		

HOW DECISIONS ARE MADE

The claims administrator uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The claims administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the precertification phone number on the back of your identification card.

If you are not satisfied with the plan's decision under this section of your benefits, you may call the Member Services phone number on the back of your Identification Card to find out what rights may be available to you.

DECISION AND NOTICE REQUIREMENTS

The claims administrator will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, the plan will follow state laws. If you live in and/or get services in a state other than the state where your plan was issued, other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	Timeframe Requirement for Decision
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	5 business days from the receipt of the request
Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	5 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the claims administrator will tell the requesting physician of the specific information needed to finish the review. If the plan does not get the specific information it needs by the required timeframe identified in the written notice, the claims administrator will make a decision based upon the information received.

The claims administrator will notify you and your physician of the plan's decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

For a copy of the medical necessity review process, please contact Member Services at the telephone number on the back of your Identification Card.

Revoking or modifying a Precertification Review decision. The claims administrator will determine **in advance** whether certain services (including procedures and admissions) are medically necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this plan ends;

- The agreement with the plan administrator terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under the plan change so that the service is no longer covered or is covered in a different way.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual case management program enables the claims administrator to assist 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 will discuss possible options for an alternative plan of treatment which may include services not covered under this plan. It is not your right to receive individual case management, nor does the claims administrator have an obligation to provide it; the claims administrator provides these services at their sole and absolute discretion.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

The health plan individual case management program (Case Management) helps coordinate services for members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate members who agree to take part in the Case Management program to help meet their health-related needs.

The Case Management programs are confidential and voluntary, and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any covered services you are receiving.

If you meet program criteria and agree to take part, then claims administrator will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating physicians, and other providers.

In addition, the claims administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

A decision will be made case-by-case if in the claims administrator's discretion, the alternate or extended benefit is in the best interest for you and the plan and you or your authorized representative agree to the alternate or extended benefit in writing.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, the plan may provide benefits for alternate care that is not listed as a covered service. The claims administrator may also extend services beyond the benefit maximums of this plan. A decision will be made case-by-case, if in the claims administrator's discretion the alternate or extended benefit is in the best interest for you and the plan and you or your authorized representative agree to the alternate and extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The claims administrator reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the claims administrator will notify you or your authorized representative in writing.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, the claims administrator may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in the claims administrator's discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, the claims administrator may select certain qualifying health care providers to participate in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The claims administrator may also exempt claims from medical review if certain conditions apply.

If the claims administrator exempts a process, health care provider, or claim from the standards that would otherwise apply, they are in no way obligated to do so in the future, or to do so for any other health care provider, claim, or member. The claims administrator may stop or modify any such exemption with or without advance notice.

The claims administrator also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then the claims administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this plan's members.

You may determine whether a health care provider participates in certain programs by checking the online provider directory on the claims administrator's website at www.anthemcom/ca or by calling the Member Services telephone number listed on your ID card.

APPEALING A UR DETERMINATION (APPEALS PROCESS):

You may request an appeal of any adverse review decision made during the precertification, concurrent review, post-service review, Health Plan Individual Case Management process described in this chapter. To appeal a denied claim/bill, see the Claim Filing and Appeal Information chapter of this document.

FAILURE TO FOLLOW REQUIRED UTILIZATION REVIEW PROCEDURES: NON-CERTIFICATION PENALTY (VERY IMPORTANT INFORMATION)

If you don't follow the Precertification Review procedures, the following penalties apply:

- The maximum allowed amount is **reduced by 50%** each time you are admitted to a **hospital or residential treatment center** without properly obtaining certification. This penalty will be deducted from the maximum allowed amount prior to calculating the amount payable by the Plan, and any benefit payment will be based on such reduced maximum allowed amount. You are responsible for paying this extra expense. This non-certification penalty (reduction) will be waived only for an emergency admission or procedure.
- **If you fail to obtain precertification for services requiring review by the Utilization Review Company then no benefits are payable.**
- You must obtain precertification (pre-service review) for services related to the **treatment of Pervasive Developmental Disorder or autism** in order for these services to be covered by this plan (see the Utilization Review chapter). **No benefits are payable** for these services if pre-service review is not obtained.

The difference between the amounts you would be responsible for paying based on the benefits that would be payable if the review procedure had been followed and the actual benefits payable because the review procedure was not followed will not accumulate to meet the Plan's Deductible.

See also the Claim Filing and Appeals Information chapter of this document.

MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusion.

GENERAL EXCLUSIONS (applicable to all medical services and supplies)

1. **Education or Counseling.** Any educational treatment or nutritional counseling, or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us. Such services are provided under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions in the Schedule of Medical Benefits. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa. This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the row of the Schedule of Medical Benefits on "Pervasive Developmental Disorder or Autism."
2. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the County of Sonoma, or if benefits are otherwise provided under this Plan or any other plan that the County of Sonoma contributes to or otherwise sponsors, such as HMOs.
3. **Expenses Exceeding Maximum Plan Benefits/Excess Amounts:** Expenses that exceed any Plan benefit limitation Maximum Plan Benefit as described in the Medical Expense Benefits chapter and Schedule of Medical Benefits section of this document.
4. **Expenses Exceeding Maximum Allowed Amounts:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Maximum Allowed Amount as defined in the Definitions chapter of this document.
5. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Subrogation and Reimbursement in the chapter on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
6. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical program; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
7. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational or Unproven as defined in the Definitions chapter of this document. However, if you have a life-threatening or seriously debilitating condition and the claims administrator determines that requested treatment is not a covered service because it is experimental or investigational, you may request an independent medical review.
8. **Government Treatment.** Any services actually given to you by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. The plan will not cover payment for these services if you are not required to pay for them or they are given to you for free.
9. **No-Cost Services/Voluntary Payment:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:
   a. It must be internationally known as being devoted mainly to medical research;
   b. At least 10% of its yearly budget must be spent on research not directly related to patient care;
   c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
   d. It must accept patients who are unable to pay; and
   e. Two-thirds of its patients must have conditions directly related to the hospital's research.

10. **Crime or Nuclear Energy.** Conditions that result from: (1) your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; 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.
11. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document, except for certain wellness benefits as outlined in the Schedule of Medical Benefits. Medically necessary includes wellness/preventive services as noted in the Schedule of Medical Benefits in this document and includes prophylactic surgery/treatment that is determined to be medically necessary by the Plan Administrator or its designee. For example, surgery to remove the breasts and/or ovaries of a woman who has a genetic mutation demonstrating a significant hereditary predisposition of breast and/or ovarian cancer, even though at the time the surgery is to be performed there is no objective evidence of the presence of cancer.
12. **Air conditioners.** Air purifiers, air conditioners, or humidifiers.
13. **Not Prescribed by a Physician**: Expenses for services/supplies that are not recommended or prescribed by a Physician, except for those covered services provided by a licensed or certified Health Care Practitioner.
14. **Not Specifically Listed**. Services not specifically listed in this Plan as covered services.
15. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** 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 Subrogation and Reimbursement in the Coordination of Benefits chapter.
16. **Personal Items:** Any supplies for comfort, hygiene, or beautification.
17. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.
18. **Relatives Providing Services:** 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 Health and Home Infusion Therapy" row of the Schedule of Medical Benefits.
19. **Services Received Outside of the United States:** Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.
20. **Hypnosis/hypnotherapy** (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness).
21. **Clinical Trials.** Services and supplies in connection with clinical trials, except as specifically stated in the "Clinical Trials" row of the Schedule of Medical Benefits.
22. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.
23. **Private Contracts.** Services or supplies provided pursuant to a private contract between the *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
24. **Chronic Pain.** Treatment of chronic pain, except as specifically provided under the "Acupuncture," "Hospice Care," or "Home Infusion Therapy" provisions in the Schedule of Medical Benefits.
25. **Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests that could have been performed safely on an outpatient basis.
26. **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery, or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the Medical Plan claims administrator.
27. **Marriage Counseling.** Marriage counseling not associated with the treatment of mental health and substance abuse conditions.

28. **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by the Medical Plan claims administrator. This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the Pervasive Developmental Disorder or Autism row of the Schedule of Medical Benefits.
29. **Telephone and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine.
30. **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 "Preventive Care Services" provisions of the Schedule of Medical Benefits.
31. **Private Duty Nursing.** Inpatient or outpatient services of a private duty nurse.
32. Expenses for and related to **Service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. Acupuncture. Acupuncture treatment, except as specifically stated in the "Acupuncture" row of the Schedule of Medical Benefits. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

B. Cosmetic Services Exclusions

1. **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.

   Examples of services that are not covered include voice and communication therapy, breast augmentation, hair removal, facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, and various other cosmetic/aesthetic procedures.

   The Medical Plan **does** cover Medically Necessary Reconstructive Services. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Plan Participants should use the Plan's Precertification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or Medically Necessary Reconstructive Services.
2. **Scalp hair prostheses**. Scalp hair prostheses, including wigs, toupees, or for any hair replacement.

C. Custodial Care Exclusions

1. **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 in the Schedule of Medical Benefits. Services provided by a rest home, a home for the aged, a nursing home, an assisted living arrangement, or a memory care/dementia care facility, or any similar facility. Services provided by a skilled nursing facility, except as specifically stated in the "Skilled Nursing Facility" row of the Schedule of Medical Benefits.

D. Dental Services Exclusions

1. **Orthodontia.** Braces and other orthodontic appliances or services.
2. **Dental Services or Supplies.** Dental plates, bridges, crowns, caps, or other dental prostheses, dental implants, dental services, extraction of teeth including wisdom 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" row of the Schedule of Medical Benefits. Cosmetic dental surgery or other dental services for beautification.
3. **Jaw Joint Disorders.** Services and supplies 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.

E. Drugs, Medicines and Nutrition Exclusions

1. **Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs or medications and insulin, except as specifically stated in the Schedule of Medical Benefits under "Home Health and Home Infusion Therapy", or "Preventive Care Services" provisions of the Schedule of Medical Benefits. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specifically stated in this benefit booklet. Cosmetics, health or beauty aids.
2. **Specialty Pharmacy Drugs.** Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this Plan. **You will have to pay the full cost of the specialty pharmacy drugs you get from a retail pharmacy that you should have obtained from the specialty pharmacy program**.
3. **Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specifically stated in the Family Planning or Drug row of the Schedule of Medical Benefits.
4. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route, duration and frequency for which they are prescribed (*i.e.* are used "off-label"); or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
5. Gene therapies are not covered under the Prescription Drug Program. Please see the Gene Therapy row of the Schedule of Medical Benefits for benefits available under the medical benefit.
6. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except certain types of insulin and certain over-the-counter(OTC) medication prescribed by a Physician or Health Care Practitioner, to be covered without cost-sharing in accordance with Health Reform regulations.
7. **Food or Dietary Supplements.** Nutritional and/or dietary supplements and medical foods, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. (Note only certain medical foods are payable in the Foods row of the Schedule of Medical Benefits).
8. Drugs, medicines, or devices for:
   (a) non-prescription male contraceptives, such as condoms.
   (b) fertility/infertility drug products or agents;
   (c) dental products such as fluoride preparations (except as mandated by Health Reform);
   (d) hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
   (e) growth hormone and growth/height promotion drugs;
   (f) cosmetic/anti-wrinkle products such as Restylane and Renova;
   (g) anti-obesity medications;
   (h) medical marijuana, except FDA-approved tetrahydrocannabinol (e.g. Marinol).
9. Compounded prescriptions in which there is not at least one ingredient that is a covered drug.
10. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.
11. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals. This exclusion does not apply to patients in a Long Term Care facility which dispenses/requires single dose drug packaging.
12. **Self-help devices** such as a scale for weight or body fat measurement, pill crusher, pill splitter, magnifying glass/device, blood pressure measurement device, etc. except that a spacer is payable with an inhaler and a peak flow meter is payable.

F. Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

G. Fertility and Infertility Services Exclusions

1. **Sterilization Reversal.** Reversal of sterilization.
2. **Infertility Treatment.** The Medical Plan does cover fertility and infertility services including evaluation (diagnosis) and surgical repair; however any other services, drugs or supplies are not covered including but not limited to artificial insemination, in vitro fertilization, gamete intrafallopian transfer, sterilization reversal, donor egg/sperm, cryostorage fees, ovarian transplant, and adoption expenses.
3. **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

H. Foot Care/Hand Care Exclusions

1. Expenses for **routine foot care**, (routine foot care includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, preventive care with assessment of pulses, skin condition, and sensation), unless the Plan Administrator or its designee determines such care to be Medically Necessary.
2. Expenses for **hand care** including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury, or symptoms involving the hand, unless the Plan Administrator or its designee determines such care to be Medically Necessary.
3. **Orthopedic Supplies**. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the Corrective Appliances row of the Schedule of Medical Benefits under the "Prosthetic Devices" provision.

I. Gene Therapy Exclusions

The Plan does not include benefits for the following:

1. Services determined to be Experimental / Investigational;
2. Services provided by a non-approved Provider or at a non-approved Facility; or
3. Services not approved in advance through Precertification.

J. Genetic Testing and Counseling Exclusions

1. Genetic Testing and Counseling is not covered unless the Plan Administrator or its designee determines such services to be Medically Necessary or mandated to be covered under Health Reform.

K. Hair Exclusions

1. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees, scalp hair prostheses, hair replacement and/or hairpieces, or hair analysis.

L. Hearing Care Exclusions

1. **Hearing Aids or Tests.** Hearing aids and routine hearing testing except as specifically stated in the Schedule of Medical Benefits.
2. Expenses for and related to hearing aid batteries and other hearing aid accessories including Dri-Aid kits for hearing aid moisture removal and phone pads.

M. Home Health Care Exclusions

1. **For the EPO Plan:** home health care.

N. Maternity/Family Planning/Contraceptive Exclusions

1. **Contraception:** Expenses related to non-prescription male contraceptive drugs and devices, such as condoms.
2. Expenses for **childbirth education, Lamaze classes**. This exclusion does not apply to the extent that breastfeeding support, supplies and counseling are covered for women in accordance with Health Reform.
3. Expenses related to the **maternity care and delivery expenses associated with a pregnant dependent child or a surrogate mother's pregnancy, delivery and complications (except when the surrogate mother is a covered Employee, Retiree or Dependent Spouse).** This exclusion of maternity care for a pregnant dependent child does not apply to the extent the expenses qualify as prenatal and postnatal office visits and mandated preventive services under Health Reform as provided under the Wellness and Preventive Services row of the Schedule of Medical Benefits, but the exclusion does apply to maternity services that are not office visits or mandated care, such as ultrasounds and delivery expenses.
4. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

For Nondurable supplies (see Corrective Appliances)

O. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. **Outpatient occupational** therapy, except when medically necessary and provided by a home health agency, hospice or home infusion therapy provider. This exclusion also does not apply to the medically necessary treatment of severe mental disorders, or to the medically necessary treatment of pervasive developmental

disorder or autism, to the extent stated in the rows on Pervasive Developmental Disorder or Autism in the Schedule of Medical Benefits.

2. **Outpatient speech therapy** except as stated in the Rehabilitation Services row of the Schedule of Medical Benefits. This exclusion also does not apply to the medically necessary treatment of severe mental disorders, or to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the rows on Pervasive Developmental Disorder or Autism in the Schedule of Medical Benefits.
3. **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 Chiropractic Services" provisions of the Schedule of Medical Benefits. This exclusion also does not apply to the medically necessary treatment of severe mental disorders, or to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the row of the Schedule of Medical Benefits on Pervasive Developmental Disorder or Autism.

P. Transplant (Organ and Tissue) Exclusions

1. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
2. For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is a person covered by this Plan.

Q. Vision Care Exclusions

1. **Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Preventive Care Services" in the Schedule of Medical Benefits. Eyeglasses or contact lenses, except as specifically stated in the Corrective Appliances row of the Schedule of Medical Benefits.
2. **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.

R. Weight Management and Physical Fitness Exclusions

1. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Weight Management" row of the Schedule of Medical Benefits.
2. **Health Club Memberships.** Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.
3. Expenses for exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

CLAIM FILING AND APPEAL INFORMATION

This chapter describes the procedures for filing claims for certain benefits under this Plan and for appealing Adverse Benefit Determinations in connection with those claims in compliance with 29 CFR §2560.503-1. Claims covered by these procedures include those claims filed and appeals related to the self-funded EPO and PPO Medical Plans, including the outpatient Prescription Drug Program benefits.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This chapter also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document.

WHEN YOU MUST REPAY PLAN BENEFITS

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the health care expenses were not payable by you or your covered Dependent; or
2. you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
3. you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (See also the Third Party Recovery section of the COB chapter);or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

then, the Plan will be entitled to

a. recover overpayments from the entity to which the overpayment was made or from the participant directly;

b. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;

c. offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or

d. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

RIGHT OF RECOVERY

If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, the Plan has the right to make appropriate adjustment to claims, 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. In the event the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the *claims administrator* will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if the claims administrator pays your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, the claims administrator may collect such amounts directly from you. You agree that the claims administrator has the right to recover such amounts from you.

The claims administrator has oversight responsibility for compliance with provider and vendor and subcontractor contracts. The claims administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

The claims administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The claims administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The claims administrator may not provide you with notice of overpayments made by the plan or you if the recovery method makes providing such notice administratively burdensome.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

Certain timing claim filing requirements pertain to network providers; otherwise, all claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information.
The Plan is not legally required to consider information submitted after the stated timeframe.

COORDINATION OF BENEFITS (COB) PROVISION

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits chapter for more information.

RESPONSIBILITY FOR TIMELY NOTICE

The Plan is 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 the Plan's liability reduced accordingly. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

ADDITIONAL INFORMATION NEEDED

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby.

COMPLYING WITH MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

AUTHORIZED REPRESENTATIVE

The Medical Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan).

An authorized representative under this Plan can include a network Health Care Professional. The Plan will accept a written statement by a network Health Care Professional that he/she is appealing on the plan participant's behalf, as an acceptable authorized representative. The written statement should include the plan participant's name and contact information along with the authorized representative's name, address and phone number. The authorized representative statement should be submitted to the Medical Plan Claims Administrator.

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Medical Plan Claims Administrator.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

YOUR RIGHT TO APPEALS FOR MEDICAL PLAN BENEFITS

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

A **pre-service claim** is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.

A **post-service claim** is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved; the specific reason(s) for the denial;
- state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
- a reference to the specific plan provision(s) on which the claims administrator's determination is based;
- give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim
- a description of any additional material or information needed to perfect your claim and an explanation of why the additional material or information is needed;
- a description of the plan's review procedures (internal appeal review and external review when applicable) and the time limits that apply to them,
- a statement of your right to bring a civil action under ERISA (if applicable) within one year of the appeal decision if you submit an appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law,
- If you do not understand English and have questions about a claim denial, contact information for assistance will be provided.
- The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

For claims involving urgent/concurrent care:

- the claims administrator's notice will also include a description of the urgent/concurrent review process; and
- the claims administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include Your Member Identification Number when submitting an appeal.

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

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

The claims administrator will also provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the claims administrator considers your appeal, the claims administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

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

Notification of the Outcome of the Appeal

- **If you appeal a claim involving urgent/concurrent care**, the claims administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

- **If you appeal any other pre-service claim**, the claims administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

- **If you appeal a post-service claim**, the claims administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

If the Plan fails to strictly adhere to its internal claims and appeals requirements, the Plan participant is deemed to have exhausted the Plan's internal claims and appeals process and can initiate a request for a voluntary external review (when external review is applicable) or can proceed with legal action.

Appeal Denial

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

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within **60 calendar days** of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

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

You must submit your request for External Review to the claims administrator within **four (4) months** of the notice of your final internal adverse determination.

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

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

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

All other requests for External Review should be submitted in writing unless the claims administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include Your Member Identification Number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit.

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

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

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Appropriate Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

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

COORDINATION OF BENEFITS (COB)

HOW DUPLICATE COVERAGE OCCURS

This chapter describes the circumstances when you or your covered Dependents may be entitled to health care benefits under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. In this chapter the term "you" references all covered Plan Participants. In many of those cases, either this Plan or the other source of coverage (the primary plan or program) pays benefits or provides services first, and the other coverage (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

- Another group or individual non-group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers' compensation.
- Coverage resulting from a judgment at law or settlement.
- Any responsible third party, its insurer, or any other source on behalf of that party.
- Any first party insurance (e.g. medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage).
- Any policy from any insurance company or guarantor of a third party
- Any other source (e.g. crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party. Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

This chapter describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the Plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this chapter). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

Coordination of Benefits or COB applies to members who are covered by more than one health care plan (meaning they have duplicate coverage), and helps ensure that these members will receive the benefits they are entitled to while avoiding overpayment by either plan. When a member is covered by more than one health plan (for example, when a spouse is covered under this group plan as well as under the spouse's own employer sponsored health plan), one plan is considered to be the primary payer and the other is considered to be the secondary payer. The primary payer covers the major portion of the bill according to that Plan's allowances, and the secondary payer covers some or all of the remaining allowable expenses. Other types of duplicate coverage include but are not limited to Medicare, Medicaid, motor vehicle insurance, or third party liability insurance.

> **Members who are covered by more than one medical plan must let this Plan's Claims Administrators know about all the additional medical coverages they have.** Please contact the Medical Plan Claims Administrator (contact information is on the Quick Reference Chart in the front of this document).

The COB provisions of each plan determine which plan is primary. Benefits are then coordinated among all of the health plans, and payments do not typically exceed 100% of charges for the covered services. In some instances, this Plan will

not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when a member actually recovers some or all of their losses from a third party (see also the Third Party Liability provisions in this chapter). This chapter describes the COB provisions of this Plan.

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, as shown below. These coordination provisions apply separately to each member, per plan year, and are largely determined by California law. Any coverage you have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense. The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

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 trusteed 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

This provision will apply in determining a person's benefits under This Plan for any plan year if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that plan year.

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

ORDER OF BENEFITS DETERMINATION

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

1. An individual plan (that is, a non-group plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, group practice, individual practice plan, or through the Health Insurance Marketplace, pays first; and this Plan pays second.
2. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases except when the law requires that This Plan pays before Medicare.
3. A plan which covers you as a subscriber pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

   For example: You are covered as a retired employee under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired employee would pay last.
4. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the plan year pays before the plan of the parent whose birthday falls later in the plan 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 4: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 4:

   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.
5. For a dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a Spouse's plan, the order of benefits shall be determined, as described in Rule 7 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 3) applies between the dependent child's parent's coverage and the dependent spouse's coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their Spouse, this Plan looks to Rule 7 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent child or the employee-spouse covering the dependent child.
6. 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.
7. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan

do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

8. 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. The Plan is 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, this Plan has the right to pay that Other Plan any amount this Plan determines to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy 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, this Plan has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

If you are entitled to Medicare, you will receive the full benefits of this plan, except as listed below:

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

In cases where exceptions 1 or 2 apply, the claims administrator's payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

Coordinating Benefits With Medicare. When this plan is secondary to Medicare, the plan will not provide benefits under this plan 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 the maximum allowed amount for the covered services.

The claims administrator will apply any charges paid by Medicare for services covered under this plan toward your plan deductible, if any.

THIRD PARTY LIABILITY

SUBROGATION AND REIMBURSEMENT

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

Subrogation

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

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

Reimbursement

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

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

- The plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole

Your Duties

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

The plan administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this plan in its entirety and reserves the right to make changes as it deems necessary.

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

The plan is entitled to recover its attorney’s fees and costs incurred in enforcing this provision.

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

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

See also the Extension of Coverage During Total Disability as explained in the Eligibility chapter.

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible employees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov or www.coveredca.com.

Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

NOTE: Domestic Partners and children of Domestic Partners (as defined in this Plan) are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (described in this chapter); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary. This chapter describes in general how the Domestic Partner COBRA-like benefit will work. Contact County of Sonoma Human Resources Benefits Unit for questions.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

COBRA Administrator: The name, telephone number, and website address of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

IMPORTANT:
This chapter serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered employees and their covered Spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this chapter carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
   - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified

Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	**Duration of COBRA for Qualified Beneficiaries[1]**		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminates (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the employer files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Retiree: for Life	Varies[2]	Varies[2]

[1]: *When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

[2]: *Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain retirees and their related Qualified Beneficiaries such as COBRA coverage for the life of the retiree. The retiree's Spouse and dependent children are entitled to COBRA for the life of the retiree and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the Qualifying Event occurs, but the retiree's surviving Spouse is alive and covered by the group health plan, then that surviving Spouse is entitled to coverage for life.*

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, **measured from the date the Qualifying Event occurs**. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months (a total of 29 months) under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan <u>in writing</u> of that event no later than <u>60 days after that Qualifying Event occurs</u>.**

That written notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is <u>not</u> received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will <u>not</u> be entitled to choose COBRA Continuation Coverage.

Officials of the employee's own employer should notify the COBRA Administrator of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or
b. **<u>you</u> notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. <u>Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage</u>. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

When COBRA Continuation Coverage of your participation in the **health care flexible spending account (Health FSA)** is available, it will be on the same terms outlined above for group health coverage, but since the person who elects COBRA will no longer be employed by their employer, it will not be possible to make contributions to the health care flexible spending account on a before-tax basis.

If you are participating in a **health flexible spending account (Health FSA)** at the time of the Qualifying Event, you will only be allowed to continue that Health FSA until the end of the current flex plan year in which the Qualifying Event occurred.

- Continuation of the Health FSA under COBRA is offered only when the employee's Health FSA is underspent when the qualifying event occurs (meaning that the underspent amount in the Health FSA exceeds the COBRA premium for that period).
- COBRA coverage is not offered to a Qualified Beneficiary who has exhausted their Health FSA, or whose Health FSA does not exceed the COBRA premium, at the time of the qualifying event.
- A Qualified Beneficiary's participation in the Health FSA will cease at the earlier of the end of the plan year in which the qualifying event occurs or if the COBRA premium payment is not made.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The County is permitted to charge the full cost of coverage for similarly situated active employees and families (including both

the County's and employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the COBRA Administrator listed on the Quick Reference Chart.]

IMPORTANT: There will be no invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.

Grace Periods

The **initial payment** for the COBRA Continuation Coverage is due to the COBRA Administrator **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent COBRA payments** are due on the first day of each month, but there will be **a 30-day grace period** to make those payments. If payments are not made within the 30-day time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall then COBRA continuation coverage will end.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the end of the month in which the last full COBRA premium payment was made.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

HIPAA Special Enrollment and COBRA

- **Addition of Newly Acquired Dependents**: If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within 31 days after the birth, adoption, or placement for adoption. The child will be entitled to the full duration of COBRA.

  If you marry while you are enrolled for COBRA, your spouse is not a Qualified Beneficiary, but the spouse can be added for the remainder of the duration of your existing COBRA coverage.

  Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

- **Loss of Other Group Health Plan Coverage:** If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or

dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Loss of coverage also includes a Dependent who loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). Enrollment in COBRA must be requested within 60 days after the Medicaid or CHIP coverage ends.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

*NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and dependents who are Qualified Beneficiaries.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the COBRA Administrator in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months (except for retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of the employee's employer.)

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:

- the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
- the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the premium payment amount due for COBRA coverage is **not paid in full and on time**;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator.
4. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).
6. The date the County no longer provides group health coverage to any of its employees.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan. To request an appeal, follow this process:

a) Send a written request for an appeal to the COBRA Administrator within 60 days of the date you received the adverse determination letter.
b) Explain why you disagree with the adverse determination.
c) Provide any additional information you want considered during the appeal process.
d) Include the most current name and address of each individual affected by the adverse determination.

The COBRA Administrator will respond in writing to this appeal within 60 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

Entitlement to Convert to an Individual Health Plan after COBRA Ends

Contact the Medical Plan Claims Administrator for information on whether it is possible to convert to an individual health plan after COBRA ends under this Plan.

COBRA Questions or To Give Notice of Changes in Your Circumstances

- If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you <u>must</u> notify the COBRA Administrator:

1. within 31 days of a **change in marital status (e.g. marriage, divorce)**; or have **a new dependent child**; or
2. within 60 days of the date you or a covered dependent Spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Brief Outline on How Certain Laws Interact with COBRA

FMLA and COBRA: Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA Qualifying Event. A Qualifying Event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the Qualifying Event—in most cases, the last day of the FMLA leave. Note that if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week (or in some cases 26 week) period, a loss of coverage could occur earlier.

Leave of Absence (LOA) <u>and</u> COBRA: If an employee is offered alternative health care coverage while on LOA, and this alternate coverage is not identical in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a Qualified Beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is less than the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18, 29, or 36 month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

California COBRA Law

If you are a COBRA participant enrolled in fully insured coverage through one of the Medical HMO and HDHP Plans, California law has a provision that affects the length of time you may continue coverage. This law only applies to the Medical HMO and HDHP Plans' coverage, not to any other benefits usually available under COBRA. If your qualifying event was low hours, termination of your employment, or retirement and you exhaust the 18 months of coverage normally available after such a qualifying event (or the 29 months available in the case of disability), you may continue your Medical HMO and HDHP Plan coverage an additional 18 months (or an additional 7 months in the case of a disability).

Note: All arrangements for additional months of coverage under the California COBRA law must be made directly with the insurer of the Medical HMO and HDHP Plans listed in the Quick Reference Chart and not through the Benefits Office.

GENERAL PROVISIONS

PLAN AMENDMENTS OR TERMINATION OF PLAN

The County reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

In order that the plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all eligible employees and retirees, the County of Sonoma Board of Supervisors expressly reserves the right, in its sole discretion at any time, but upon a non-discriminatory basis, except as may be specifically contradicted otherwise in an applicable Memorandum of Understanding (MOU) or Salary Resolution:

a. To terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and

b. To alter or postpone the method of payment of any benefit;

c. To amend or rescind any other provisions of this plan.

Amendments shall be made by resolution of the County of Sonoma Board of Supervisors, except as listed below.

The County of Sonoma Human Resources Director has the authority to amend this Plan Document in the following circumstances; 1) to reflect any changes agreed to by an employee organization and the County Board of Supervisors, 2) to update any vendor or vendor contact information, and 3) to correct any unintended clerical or administrative errors.

PROVIDING OF CARE

The County is not responsible for providing any type of hospital, medical, or similar care, nor is the County responsible for the quality of any such care received.

INDEPENDENT CONTRACTORS.

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

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.

NON-ASSIGNMENT

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental, and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

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 required monthly premium contributions are paid according to the terms of the plan.

FREE CHOICE OF PROVIDER

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

MEDICAL NECESSITY

The benefits of this plan are provided only for services which the claims administrator determines to be medically necessary. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in

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

EXPENSE IN EXCESS OF BENEFITS

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

Terms of Coverage

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

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

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

Benefits Not Transferable. Only the 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 the claims administrator properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. The plan administrator is not liable for the benefits of the plan if you do not file claims within the required time period. The plan administrator will not be liable for benefits if the claims administrator does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. The benefits of this plan will be paid directly to contracting hospitals, participating providers, CME, and medical transportation providers. If you or one of your dependents receives services from non-contracting hospitals or non-participating providers, payment will be made directly to the subscriber and you will be responsible for payment to the provider. The plan will pay non-contracting hospitals and other providers of service directly when emergency services and care are provided to you or one of your dependents. The plan will continue such direct payment until the emergency care results in stabilization. If you are a Medi-Cal beneficiary and you assign benefits in writing to the State Department of Health Services, the benefits of this plan will be paid to the State Department of Health Services. These payments will fulfill the plan's obligation to you for those covered services.

Plan Administrator - COBRA. In no event will the claims administrator be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers to County of Sonoma or to a person or entity other than the claims administrator, engaged by County of Sonoma to perform or assist in performing administrative tasks in connection with the plan. The plan administrator is responsible for satisfaction of notice, disclosure, and other obligations. In providing notices and otherwise performing under the COBRA chapter of this document, the plan administrator is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

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

Liability to Pay Providers. In the event that the plan does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the plan.

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

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

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

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

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members 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 Member Services 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.

You will be notified 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. The non-participating provider will be asked to 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, the non-participating provider's services will not be continued. 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 Member Services 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 section below.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this plan must be resolved in accordance with the plan's grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form, which you may use to explain the matter. All grievances received under the plan will be acknowledged in writing, together with a description of how the plan proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

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.

CLAIM FILING AND CLAIM APPEALS

See the Claim Filing and Appeal Determination chapter in this document.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

RIGHT OF PLAN TO REQUIRE A PHYSICAL EXAMINATION

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. This right extends to the right and opportunity to request an autopsy or other forensic exam in case of death where it is not forbidden by law. The cost of such an examination will be paid by the Plan.

HEADINGS, FONT AND STYLE DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the County of Sonoma group health plan including the self-funded medical plans discussed in this document (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the County's Human Resources Benefits Unit.

Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Supervisors for the County of Sonoma), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
  a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;
  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, Utilization Review, including precertification, concurrent review and/or retrospective review.
- **Health Care Operations** includes, but is not limited to:
  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;
  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

B. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Privacy Officer) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
3. Not use or disclose the information for employment-related actions and decisions,
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
8. Make available the information required to provide an accounting of PHI disclosures,
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. Employee benefits administration staff in the Human Resources Benefits Unit of the County of Sonoma including the County's Privacy Officer, Human Resources Deputy Director, Employee Benefits Manager, Risk Management Analyst I/II, Human Resources Technician, Senior Office Assistance, and Account Clerk I/II;
2. Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization networks, Utilization Review program, outpatient prescription drug program administrator, and COBRA administrator.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options including outpatient prescription drug benefits, COBRA administration and Health Flexible Spending Account (FSA) administration (not addressed in this medical plan document).

Protecting your privacy

Where to find Anthem's Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/health-insurance/about-us/privacy for more information.

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of Anthem's Notice of Privacy Practices on our website at https://www.anthem.com/ca/health-insurance/about-us/privacy or you may contact Member Services using the contact information on your identification card.

Notice of Privacy Practices for County of Sonoma Health Plan Members

Effective: October 1, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Privacy is Important to Us

Because we understand that medical information about you and your family members is personal, the County of Sonoma staff is committed to protecting your medical information.

This notice will tell you about the ways in which we may use and disclose medical information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

The County of Sonoma contracts with Anthem Blue Cross to administer the benefits of the County Health Plan. Anthem Blue Cross provides medical information to the County, such as claims experience reports. These reports allow the County to perform the actuarial functions necessary to evaluate plan performance and benefits, and to establish premiums.

The County of Sonoma is Required by Law to:

- Ensure that medical information that identifies you is protected from inappropriate use and disclosure.
- Ensure that genetic information is not used or disclosed to evaluate plan performance or establish premiums.
- Notify all affected individuals of a breach of unsecured protected health information.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Changes to Our Privacy Practices

We reserve the right to change our privacy practices. We reserve the right to apply the revised practices to the medical information we already have about you as well as any information we receive after the revisions are made. A copy of the most current notice is available from the County of Sonoma Human Resources Department. The effective date of the notice is on first page of the Notice of Privacy Practices in the top right-hand corner.

THE FOLLOWING INFORMATION DESCRIBES THE WAYS THAT *ANTHEM BLUE CROSS* MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION.

For Treatment

Anthem Blue Cross may use and disclose your medical information to provide, coordinate and manage your health care benefits and any related services. Anthem Blue Cross may

disclose your medical information to doctors, nurses, technicians, therapists and health care personnel who are involved in your care. Doctors and health care providers are permitted to share information about your care to help provide you with timely and appropriate health care services. For example, health care providers may share your medical information in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment

Anthem Blue Cross may use and disclose medical information about you to doctors and other health care providers that request eligibility information or treatment authorizations. Anthem Blue Cross also uses and discloses your health information so that your health care providers can bill and be paid by for the health care services you receive.

For Health Care Operations

Anthem Blue Cross may use and disclose medical information about you for our health care operations. For example, Anthem Blue Cross may use medical information to review and evaluate the benefits and services provided by the County Health Plan. Anthem Blue Cross may use your medical information to tell you about possible treatment options or alternatives or to tell you about health-related products or services that may be of interest to you. Anthem Blue Cross may use your medical information to contact you as a reminder that you should make an appointment for treatment or medical care.

As Required by Law

Anthem Blue Cross may use and disclose medical information about you as required by law. For example, disclosures of medical information may be required for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority.
- To assist law enforcement officials in their law enforcement duties.

Health Oversight Activities

Your health information may be disclosed for health oversight activities authorized by law, such as audits, investigations and inspections. Health oversight activities are conducted by state and federal agencies that oversee government benefit programs and civil rights compliance.

Organ/Tissue Donation

If you are an organ donor, Anthem Blue Cross may disclose your health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Health and Safety

Your health information may be disclosed to avert a serious threat to your health or safety or that of any other person pursuant to applicable law.

Active Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, Anthem Blue Cross will disclose your health information when required by military command or other government authorities.

Worker's Compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.

Other Uses and Disclosures of Medical Information

The County of Sonoma and Anthem Blue Cross use and disclose your medical information in a manner that complies with federal and state laws and regulations. When an authorization is required to use or disclose your medical information, such as, for the use and disclosure of inpatient mental health records, HIV test results, or substance abuse records, the use or disclosure will be made only with your written authorization. If you authorize the use and disclosure of your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, all uses or disclosures of your medical information for the purposes covered by your written authorization will cease unless we have already acted in reliance on your authorization. We are unable to take back any disclosures we have already made prior to revoking your authorization.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

If you have any questions about this Notice or your individual rights regarding medical information maintained by the County of Sonoma, please contact the County of Sonoma Compliance/Privacy Officer at:
(707) 565 – 5703

All requests to exercise your individual rights and privacy related complaints must be submitted in writing to:

County of Sonoma Compliance /Privacy Officer
1450 Neotomas Avenue, Suite 200
Santa Rosa, CA 95405

Your Right to Inspect and Copy

You have the right to inspect and copy medical information maintained by the County of Sonoma that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

If you request a copy of the information, you will be charged a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

We may deny your request to inspect and copy certain medical information in very limited circumstances. A denial to of a request to inspect or copy medical information can only be made by licensed health care professionals. If your request to inspect and copy medical information is denied, you may request that the denial be reviewed. Another licensed health care professional chosen by the Compliance/Privacy Officer will review your request and the denial. The licensed health care professional conducting the review will not be the same

licensed health care professional who denied your initial request. We will comply with the outcome of the review.

Your Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the County of Sonoma.

You must provide the reason that you are requesting the amendment. We will deny your request for an amendment if it is not in writing or it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- ✓ Was not created by us, unless the person or organization that created the information is no longer available to make the amendment.
- ✓ Is not part of the medical information kept by or for the County of Sonoma.
- ✓ Is not part of the information which you would be permitted to inspect and copy.
- ✓ Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Your Right to an Accounting of Disclosures

You have the right to request an accounting of disclosures we made of medical information about you, other than disclosures for treatment, payment, health care operations, or pursuant to a valid authorization.

Your request must include a time period. The time period may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list of disclosures (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Your Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request to receive communications about your health care by an alternate means or at alternative locations.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or for the purposes of public health reporting or as required by law. We will accommodate all reasonable requests. If you wish to request a restriction or limitation on the use or disclosure

of your medical information, your written request must tell us:

- ✓ What information you want to limit.
- ✓ Whether you want to limit our use, disclosure or both.
- ✓ To whom you want the limits to apply, for example, disclosures to your spouse.

If you wish to request that communications regarding your medical information be provided using alternate means or locations, your written request must specify:

- ✓ How or where you wish to be contacted.
- ✓ The method you would like us to use to communicate with you, for example, the alternative address, phone number or email address.

Your Right to Receive a Paper Copy of This Notice

You may ask us to give you a copy of this notice at any time. You may request that a copy be sent to you by contacting the County of Sonoma Compliance Message Line at (707) 565 – 5703. Please state that you wish to receive a Notice of Privacy Practices and provide your name and mailing address. A copy will be sent to you within 5 business days of your request. Or, you may obtain a copy of this notice on the County of Sonoma Intranet site. Go to Privacy Information.

Complaints

If you believe your privacy rights related to the management of your health information maintained by the County of Sonoma have been violated you may file a complaint with our Compliance/Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with the County of Sonoma please submit your complaint to:

County of Sonoma Compliance /Privacy Officer
1450 Neotomas Avenue, Suite 200
Santa Rosa, CA 95405

Complaints must be submitted in writing. You will not be penalized for filing a complaint.

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The County of Sonoma complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The County of Sonoma does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The County of Sonoma:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact the County's Civil Rights Coordinator.

If you believe that the County of Sonoma has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

County of Sonoma Civil Rights Coordinator
ATTN: Human Resources Equal Employment Opportunity and Americans with Disabilities Act
575 Administration Drive, Room 116 B
Santa Rosa, CA 95403
Phone: (707) 565-2331
Fax: (707) 565-3770
Email address: Benefits@Sonoma-County.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the County's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

Free Language Assistance: The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of California:

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (707) 565-2331.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (707) 565-2331
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (707) 565-2331.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (707) 565-2331.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (707) 565-2331 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (707) 565-2331:
Persian (Farsi)	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (707) 565-2331 تماس بگیرید.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (707) 565-2331.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(707) 565-2331 まで、お電話にてご連絡ください。

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (707) 565-2331. اتصل برقم
Punjabi	ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (707) 565-2331 'ਤੇ ਕਾਲ ਕਰੋ।
Cambodian	្របយ័ត៖ េបើសិនអកនិយ ែខរ, េសជំនួយែផក េយមិនគិតឈល គឺចនសំប់បំេរអក។ ចូរ ទូរស័ព (707) 565-2331។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (707) 565-2331.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। (707) 565-2331 पर कॉल कर।
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (707) 565-2331.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to claims administration and claim appeals are found in the Claim Filing and Appeals Information chapter of this document.

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

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

Adverse Benefit Determination: See the Claim Filing and Appeal Information chapter for the definition.

Allowed Charge: See Maximum Allowed Amount.

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the Plans covering a Plan Participant (this term is further discussed in the COB chapter of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an Allowable Expense.

Ambulance, Professional Ambulance Service: means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is

a) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
b) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
c) provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless and in need of immediate medical transportation; or
d) are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

Non-emergency medical transportation services are not payable by this Plan.

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

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the Physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:

a. the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA) or Certified Surgical Assistant (CSA, SA-C), but not an employee of a hospital or surgical facility or a medical student, intern or other trainee; and
b. the use of an assistant surgeon(s) is determined by the Plan Administrator or its designee to be Medically Necessary; and
c. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Authorization/Authorized: means the approval given by the Plan's Utilization Review Company or Prescription Drug Program for a service that requires preapproval/preauthorization, such as for an elective hospital admission or a specialty drug.

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a non-participating provider, or require special services or facilities not available at a contracting hospital, but only when the referral has been authorized by the claims administrator before services are rendered and when the following conditions are met:

1. there is no participating provider who practices in the appropriate specialty, or there is no contracting hospital which provides the required services or has the necessary facilities;
2. that meets the adequacy and accessibility requirements of state or federal law; and
3. the member is referred to hospital or physician that does not have an agreement with Anthem for a covered service by a participating provider.

Authorized Representative: See the Claim Filing and Appeal Information chapter for the definition.

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Maximum Allowed Amounts and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Limit is reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Maximum Allowed Amount. Remember, amounts exceeding the Maximum Allowed Amount do not count toward the Plan's Out-of-Pocket Limit and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing**. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the plan's payment for a covered service. Generally, you can avoid balance billing by using In-Network providers for covered services. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using In-Network providers.**

Bariatric CME Coverage Area is the area within the 50-mile radius surrounding a designated bariatric CME.

Behavioral Health Disorder: Behavioral Health is an umbrella term that refers to mental health and/or substance abuse. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Beneficiary: See the COBRA chapter for information on Qualified Beneficiary.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Maximum Allowed Amount, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's exclusions, limitations and maximums.

Benefit Booklet (benefit booklet) is this written description of the benefits provided under the plan.

Benefit Year: See Plan Year.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center.
   - is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
   - has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - provides at least two beds or two birthing rooms.
   - is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - has trained personnel and necessary equipment to handle emergency situations.
   - has immediate access to a blood bank or blood supplies.

- has the capacity to administer local anesthetic and to perform minor Surgery.
- maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
- is expected to discharge or transfer patients within 48 hours following delivery; and
- is accredited by the American Association of Birth Centers (AABC).

A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Calendar Year: The 12-month period beginning January 1 and ending December 31.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. See the Rehabilitation row of the Schedule of Medical Benefits for information on when cardiac rehabilitation services are payable.

Case Management: A process, administered by the Utilization Review Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the County to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Centers of Medical Excellence (CME) are health care providers designated by the claims administrator as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the claims administrator at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the maximum allowed amount as payment in full for covered services. A participating provider in the Anthem Blue Cross Prudent Buyer Plan network is not necessarily a CME.

Chemical Dependency: This is another term for Substance Abuse/Substance Use Disorder. See also the definitions of Behavioral Health Disorders and Substance Abuse/Substance Use Disorder.

Child(ren): See the definition of Dependent Child(ren) and children of Domestic Partner.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Claim, Claimant: See the Claim Filing and Appeal Information chapter for the definition.

Claims Administrator: The independent companies retained by the Plan to administer the medical and outpatient prescription drug claim processing and payment responsibilities and other administration or accounting services as specific by the Plan. The contact information for the various Claims Administrators is listed on the Quick Reference Chart in the front of this document.

COBRA: means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to temporary continuation of health care coverage. See the COBRA chapter of this document for more information.

Coinsurance: That portion of Eligible Medical Expenses for which the covered person has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after the Plan's deductible has been met. Coinsurance amounts are listed in the Schedule of Medical Benefits.

Compound Drugs: See the definition of Prescription Drugs.

Concurrent Care Claim: See the Claim Filing and Appeal Information chapter for the definition.

Concurrent Review: A managed care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, surgery and other health care services are Medically Necessary by having the Utilization Review (UR) Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility. Also called Continued Stay Review.

Contracting hospital is a hospital which has a Standard Hospital Contract in effect with the claims administrator 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 Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services, generally those provided by In-Network Health Care providers or facilities. The services with a copay are listed on the Schedule of Medical Benefits in this document.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: surgery or treatment is 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 as determined by the claims administrator or its designee. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons. The Plan Administrator or its designee determines if a surgery or treatment is considered to be cosmetic.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Cost-sharing: A term to mean the amount of money a plan participant pays toward a service or item, versus the amount of money the Plan pays. Plans typically have three different types of cost-sharing charges: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these three types of cost-sharing.

Covered Individual: Any employee, retiree and that person's eligible Spouse or Dependent Child or Domestic Partner (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A covered individual is also referred to as a Plan Participant.

Covered Medical Expenses: See the definition of Eligible Medical Expenses.

Custodial Care: Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self- administered or any other care which does not require continuing services of medical personnel. Some examples of Custodial Care are helping patients with their activities of daily living like help to get in and out of bed, eating, using the toilet, walking (ambulating), or taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care or in conjunction with covered home health services.

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of mental health or substance abuse conditions under the supervision of physicians.

Days (as relates to claim filing and appeals): See the Claim Filing and Appeal Information chapter for the definition.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the Medical Expense Benefits chapters of this document.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental includes outpatient prescription drugs prescribed by a dentist, Physician or Health Care Practitioner for a dental purpose such as fluoride tablets. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are **not covered** under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise in the Schedule of Medical Benefits.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse or Domestic Partner, or child of a Domestic Partner as those terms are defined in this document. See also the definition of Dependent Child, Spouse, Domestic Partner, and child of a Domestic Partner.

Dependent Child(ren): For the purposes of this Plan, a Dependent Child is any of the employee's, retiree's or Domestic Partner's children listed below through the last day of the month in which they reach age 26 (whether married or unmarried):

- **Natural child (son or daughter)** Proof of relationship and age may be required.
- **Stepchild (stepson or stepdaughter)** Proof of relationship and age may be required.

- **Adopted child.** Proof of adoption or placement for adoption and age may be required. Under this Plan, an adopted child means a child who is in the process of being adopted is considered a legally adopted child if the County receives legal evidence of both: (i) the intent to adopt; and (ii) that the employee, retiree, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the Employee's, Retiree's, Spouse's or Domestic Partner's right to control the health care of the child.
- A child named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)**.
- **Foster child**, lawfully placed with the employee/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (proof of relationship, age and foster child placement will be required).
- **Child under a Legal Guardianship Order.** A child for whom the employee, retiree, spouse or Domestic Partner is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). The County's Human Resource Benefits Unit must receive legal evidence of the decree (the court-appointed legal guardianship documents and certified birth certificate).

Additional Dependent Children: In addition to the Dependent Children defined above, the following Disabled Adult Child is eligible for coverage under the Plan:

- **Disabled Adult Child:** A disabled adult child may be eligible to continue benefits beyond the age of 26. A physician must certify this disability in writing. The Plan will require initial and periodic proof of disability.

  Initially, the Plan must receive the disability certification within 31 days of the date the child otherwise becomes ineligible for coverage under this Plan. When a period of two years has passed, the County may request proof of continuing dependency and disability, but not more often than once each year. This proof of continuing disability (to be provided within 31 days of a request for proof of disability) will last until the child is no longer disabled or dependent on the employee, retiree, spouse or domestic partner for financial support.

  To be eligible as a disabled adult child, the individual must meet all of the following eligibility requirements:

  a. is an **unmarried** Dependent Child (as defined above) of a covered Employee, Retiree or Domestic Partner; and
  b. is **age 26 or older**; and
  c. is **permanently and totally disabled** (under this Plan totally disabled child means a dependent who has been determined to be disabled by a Physician, based on Social Security criteria.); and
  d. the **Disability existed prior to the individual reaching age 26**; and
  e. **the child was covered under this Plan on the day before their 26th birthday;** and
  f. **the child is financially dependent on the Employee, Spouse, or Domestic Partner for more than half of his or her support**, (a child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes); and
  g. the **child is incapable of self- sustaining employment** due to a physical or mental disability.

  A child whose coverage has terminated due to reaching the age limit and then becomes disabled, is not eligible to re-enroll as a Dependent child under this Plan.

With the exception of a Dependent Child who is permanently and totally disabled prior to age 26, coverage will terminate at the end of the month in which the individual attains age 26. See also the termination provisions for Dependent Children listed in the Eligibility chapter of this document.

The following individuals are not eligible under the Plan: a spouse of a Dependent Child (e.g. employee/retiree's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee/retiree's grandchild) unless the employee/retiree have legal guardianship over the child.

The term "child" does not include any person who is: (i) covered as an employee; or (ii) in active service in the armed forces. No individual may be covered under this Plan both as an employee or retiree and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one employee or retiree.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis), **and** the person is permanently and totally disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See also the definition of Totally Disabled.

Domestic Partner: For the purposes of this Plan, a Domestic Partner is same-sex or opposite-sex partner registered with the State of California or, for certain bargaining units only, attested to on a County of Sonoma Affidavit of Domestic Partnership Benefits. The Plan requires proof of Domestic Partner relationship, such as but not limited to the submission of a copy Declaration of Domestic Partnership per California Family Code section 297**.**

A domestic partner is not also considered a Spouse under this Plan.

Coverage of a Domestic Partner ends in accordance with the section of "When Coverage Ends" as noted in the Eligibility chapter of this document.

Child of a Domestic Partner: If a Domestic Partner is enrolled in the Plan, the employee may also apply for coverage for the Domestic Partner's Dependent child(ren) who meet the requirements of a "Dependent Child" as that term is defined in this chapter.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable, is for the exclusive use of the patient, is not primarily for comfort or hygiene, is not for environmental control or for exercise, is manufactured specifically for medical use, and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Early Retiree: A Former County employee who are eligible to participate under the Plan as a Retiree but who is not yet eligible for Medicare.

Effective date: See the Eligibility chapter of this document.

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful Spouse and your Dependent Child(ren), Domestic Partner, [Domestic Partner's child,] as those terms are defined in this Plan. An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Medical Expenses/Eligible Charges: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are Medically Necessary, as defined in this Definitions chapter; and the charges for them are a Maximum Allowed Amount, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded; and the Limited Overall, and/or Annual Maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document. An expense is incurred on the date the service or supply is received.

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the member or unborn child.

An emergency medical condition includes a psychiatric emergency medical condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Care: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency care means medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in

serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services: means with respect to an Emergency Medical Condition (defined above), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by the County of Sonoma who is on the payroll of the County and is eligible to enroll for coverage under the Plan. See also the Eligibility provisions in the Eligibility chapter of this document.

Employer: The County of Sonoma located in northern California.

Enroll, Enrollment: The process of completing and submitting an enrollment form (hard copy or online) indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

Essential Health Benefits: The Affordable Care Act defines essential health benefits to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Medical Plan Exclusions chapter, for which the Plan does **not** provide Plan benefits.

Exclusive Provider Organization (EPO): A network of Hospitals, Physicians, medical laboratories, and/or other Health Care Providers who have agreed to provide Medically Necessary services and supplies for a fee that is less than they normally charge. Generally there is no coverage for services performed by non-EPO providers except in the case of an emergency.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter.

Experimental and/or Investigational or Unproven: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A service or supply will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Utilization Review program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is

prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.

5. Note that under the medical plans in this document, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, precertification is recommended in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:
   a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
   b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
   d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.
   e. The plan may rely on its Utilization Review Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the Claim Filing and Appeal Information chapter for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial. See the Utilization Review chapter for information on precertification requirements. In determining if a service or supply is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Utilization Review program:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the US such as Anthem Blue Cross, Aetna, CIGNA or United Healthcare, or MCG, formerly Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies.

6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, see the Precertification Review section of the Utilization Review chapter.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Facility-based care is care provided in a hospital, psychiatric health facility, residential treatment center or day treatment center for the treatment of mental health or substance abuse conditions.

Federal Legend Drugs: See the definition of Prescription Drugs.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of outpatient prescription drug products, including strength and dosages, available for use by Plan participants. A formulary is also called a Preferred drug list.

Gene Therapy: is a technique that uses human genes to treat or prevent disease in humans. Gene therapy seeks to modify or introduce genes into a patient's body with the goal of treating, preventing or potentially curing a disease. Examples of gene therapy approaches include replacing a mutated gene that causes disease with a functional copy; introducing a new, correct copy of a gene into the body; or turning off genes that cause medical problems.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking or talking at the expected age.

Handicap or Handicapped (Physically or Mentally): See the definition of Disabled.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities/Long Term Acute Care facilities as those terms are defined in this Definitions chapter.

Health Care Practitioner: Acupuncturist, Behavioral Health Practitioner (including licensed psychologist (PhD), clinical specialist psychiatric registered nurse (CSPRN), mental health or substance abuse counselor or social worker who has a Master's degree), licensed clinical social worker, certified registered nurse anesthetist(CRNA), Chiropractor, Dentist, Nurse (RN, LVN, LPN), Nurse Practitioner, Certified Nurse Midwife, Breastfeeding/Lactation Educator, Pharmacist, Physician Assistant (PA), or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant. See also the definition of Physician. Some of the terms used in this definition are also defined separately in this chapter, such as Physician Assistant. To the extent required by Health Reform regulations, a Health Care Practitioner includes a health care provider acting within the scope of the provider's license or certification under applicable State laws, and is performing a covered service under this Plan.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility, as those terms are defined in this Definitions chapter.

Home Health Care: Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
   - has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
   - has a full-time administrator.
   - is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
   - maintains written clinical records of services provided to all patients.
   - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
   - its employees are bonded.
   - maintains malpractice insurance coverage.

Home infusion therapy provider: is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by The Joint Commission (TJC).

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request (by contacting the Medical Plan Claims Administrator).

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of The Joint Commission. For the limited purpose of inpatient care for the acute phase of a mental health or substance abuse condition, "hospital" also includes psychiatric health facilities.

Hours of Service: means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for an employer; and (2) each hour for which an employee is paid, or entitled to payment by an employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Under the final regulations, an hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or to the extent the compensation for services performed constitutes income from sources without the United States.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy of a covered Employee, Retiree, Spouse or Domestic Partner will be considered to be an Illness only for the purpose of coverage under this Plan.** Prenatal and postnatal visits and Health Reform mandated preventive services for a pregnant dependent child will be covered by this Plan, but not ultrasounds and other pregnancy-related services of the pregnant dependent child, the delivery and/or newborn expenses.

Infertility: is (1) the presence of a condition recognized by a physician as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or after 3 cycles of artificial insemination.

Infusion Therapy: Infusion therapy involves the administration of medication or nutrition through a needle or catheter. It is prescribed when a patient's condition is so severe that the condition cannot be treated effectively by oral medications or other nutrition routes. Commonly administered infusion therapy includes infusion of antibiotic, antifungal, antiviral, chemotherapy, hydration, pain management, parenteral nutrition, and total parenteral nutrition or TPN. Diseases commonly requiring infusion therapy include infections that are unresponsive to oral/intramuscular antibiotics, cancer and cancer-related pain, dehydration, gastrointestinal diseases or disorders which prevent normal functioning of the gastrointestinal system, etc.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Dental services in the Schedule of Medical Benefits.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO or EPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Long Term Acute Care (LTAC) Facility: See the definition of Subacute Care Facility.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Massage: See Therapeutic Massage.

Maximum Allowed Amount is the maximum amount of reimbursement the claims administrator will allow for covered medical services and supplies under this plan.

The Maximum Allowed Amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to an In-Network provider** (PPO /EPO network Health Care or Dental Care provider/facility), the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/facility and the PPO/EPO network or the Plan; **or**
2. **With respect to a Non-Network provider**, Maximum Allowed Amount means the schedule that lists the dollar amounts the Plan or its designated claims administrator has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers.

   The Plan's Maximum Allowed Amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter;

   Exception for Cancer Clinical Trials. The maximum allowed amount for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating (in-network) provider.

   If Medicare is the primary payer, the maximum allowed amount does not include any charge:

   1. By a hospital, in excess of the approved amount as determined by Medicare; or
   2. By a physician who is a participating provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
   3. By a physician who is a non-participating provider or other health care provider who accepts Medicare assignment, in excess of the lesser of maximum allowed amount stated above, or the approved amount as determined by Medicare; or
   4. By a physician or other health care provider who does not accept Medicare assignment, in excess of the lesser of the maximum allowed amount stated above, or the limiting charge as determined by Medicare.

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

   WARNING! Reduction of the Maximum Allowed Amount for Non-Contracting Hospitals. A small percentage of hospitals which are non-participating providers are also non-contracting hospitals. Except for emergency care, the maximum allowed amount **is reduced by 25%** for all services and supplies provided by a non-contracting hospital. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a contracting hospital. **To locate a contracting hospital, you can call the Medical Plan's claims administrator's Member Services number** on your identification card (or Quick Reference Chart in the front of this document);

   or
3. For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation

or other individual insurance, or where this Plan may be a secondary payer, the Maximum Allowed Amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**

4. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Maximum Allowed Amount" amount for health care services or supplies.

Any amount in excess of the "Maximum Allowed Amount" amount does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Maximum Allowed Amount" amounts by this Plan.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Maximum Allowed Amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Review Company, Prescription Drug Program, Medical Plan Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Maximum Allowed Amount" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any special reimbursement provisions adopted by the Plan.

In accordance with federal law, with respect to emergency services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees is to pay the **greater** of:

- the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or
- 100% of the Plan's usual payment (Maximum Allowed Amount) formula (reduced for cost-sharing) or
- (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

See the definition of **emergency services** in this chapter.

NOTE: Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use a non-network provider you may be balance billed by that provider, except for emergency services performed in an emergency room. These minimum payment standards for emergency services in a hospital emergency room **do not apply** in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges.

Maximum Plan Benefits: The maximum amount of benefits payable by the Plan (and described more fully in the Medical Expense Benefits chapter of this document) on account of medical expenses incurred by any covered Plan Participant. There are two general types of plan maximums, described below:

- **Limited Overall Maximum Plan Benefits** are the maximum amount of benefits payable on account of certain covered medical services or supplies by the Plan during the entire time a Plan Participant is covered under this Plan and any previous medical expense plan provided by the County. The services or supplies that are subject to Limited Overall Maximum Plan benefits and the limits of those benefits are identified in the Schedule of Medical Benefits.
- **Annual Maximum Plan Benefits** are the maximum amount of benefits payable each Plan Year on account of certain medical expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan. Annual Maximums are identified in the Schedule of Medical Benefits.

Medically Necessary/Medical Necessity:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
   3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
      - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
      - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
      - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
      - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
      - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

H. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

I. In the absence of illness or injury, a prophylactic surgery or treatment may be considered medically necessary if: a) the individual is a high risk individual (e.g. has a significant hereditary predisposition to a serious illness or injury), b) the surgery or treatment is proven to reduce the risk of a serious illness or injury, and c) the surgery or treatment is not considered to be experimental/investigational. The Plan reserves the right to consult medical professionals to assist in the determination of high risk, serious illness or injury, and experimental/investigational.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Member is the subscriber (eligible employee or retiree) or dependent.

Mental health conditions include conditions that constitute severe mental disorders and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependence.

Mental Health; Mental Disorder; Mental and/or Nervous Disorder: See also the definition of Behavioral Health Disorder.

Midwife, licensed and Certified Nurse Midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Negotiated rate is the amount participating (in-network) providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements. See also the definition of Maximum Allowed Amount.

Non-contracting hospital is a hospital which does not have a Standard Hospital Contract in effect with the Medical Plan claims administrator at the time services are rendered.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the claims administrator at the time services are rendered:

- A hospital
- A physician
- An ambulatory surgical center

- A home health agency
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A skilled nursing facility
- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- A retail health clinic
- A hospice
- A licensed qualified autism service provider

They are not participating providers. Remember that the maximum allowed amount may only represent a portion of the amount which a non-participating provider charges for services. See the definition of Maximum Allowed Amount/Allowed Amount.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Nutritionist: means a professional who is qualified by training to evaluate people's nutritional health and needs, who plans food and nutrition programs, helps a person design meals/food choices to promote healthy eating habits and who assists the person in meeting necessary dietary modifications. To be payable by this Plan the professional must be licensed as a Nutritionist or is a Certified Nutrition Specialist or Certified Clinical Nutritionist and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant, and acts under the direction of a Physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Off-Label: Off-label prescription drugs are FDA-approved prescription drugs that are prescribed for indications other than those stated in the labeling approved by the FDA.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding.

Open Enrollment Period: The period during which an employee or retiree may add coverages of dependents, drop coverages or dependents or select among the alternate health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is described in the Eligibility chapter of this document.

Orthodontics, Orthodontia: The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures

are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or Temporomandibular Joint syndrome/dysfunction. See the definitions of Prognathism, Retrognathism, and Temporomandibular Joint syndrome/dysfunction.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Other health care provider is one of the following providers: A certified registered nurse anesthetist
- A blood bank
- A licensed ambulance company

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

Out-of-Network Services (Non-Network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO or EPO.

Out-of-Pocket Limit: The Out-of-Pocket Limit is the most you pay during a one year period (the plan year) before your medical plan starts to pay 100% for covered essential health benefits. See the Medical Expense Benefits chapter for more details.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred.

Participating Provider: A Health Care Provider who participates in one of the Plan's Preferred Provider Organizations (PPO) for those enrolled in the PPO Medical Plan or the Exclusive Provider Organization (EPO) for those enrolled in the EPO Medical Plan. A retail or mail order pharmacy that does contract with the Plan's selected Pharmacy Benefit Manager (PBM). For the EPO and PPO Medical Plan, a **Participating Provider** is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the Medical Plan claims administrator at the time services are rendered:
- A hospital
- A physician
- An ambulatory surgical center
- A home health agency
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A skilled nursing facility
- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- A retail health clinic
- A hospice
- A licensed qualified autism service provider

Participating providers agree to accept the maximum allowed amount as payment for covered services. A directory of participating providers is available upon request.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant, and acts under the direction of a Physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient or the parent, Spouse, sibling

(by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant. See also the definition of Health Care Practitioner.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

Plan, This Plan: The programs, benefits and provisions described in this document, and as formally amended. 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.

Plan Administrator: The County of Sonoma Board of Supervisors (who is also known as the Plan Sponsor) and who has the responsibility for overall Plan administration and who may contract with various independent companies to assist in the daily duties of plan administration.

Plan Participant: See the definition of Covered Individual.

Plan Sponsor: The County of Sonoma Board of Supervisors (who is also known as the Plan Administrator).

Plan Year: The twelve-month period from June 1 (at 12:01am Pacific Standard time) to May 31 is designated to be the Plan Year. The Plan year is sometimes also called the Benefit Year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant.

Post-service Claim: See the Claim Filing and Appeal Information chapter for the definition.

PPO: see Preferred Provider Organization.

Precertification: Precertification is a review procedure performed by the Utilization Review Company **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary. Precertification is also referred to as pre-service review, prior authorization, precert, prior auth or preapproval.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, Physicians, laboratories) under contract with an organization, which has a contract with the Plan, to provide health care services and supplies at agreed-upon discounted/reduced/negotiated rates. The Plan reserves the right to contract with one or more PPOs to assist in providing adequate geographic coverage for members.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.

5. **Specialty drug**: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty drugs are managed by a specialty drug pharmacy that is part of the Prescription Drug Program under contract to the Plan. See the Drug row of the Schedule of Medical Benefits for more information.

Pre-service Claim: See the Claim Filing and Appeal Information chapter for the definition.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call the Member Services number listed on your ID card for additional information about services that are covered by this plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.cdc.gov/vaccines/schedules/hcp/index.html
- http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
- http://www.hrsa.gov/womensguidelines/.

Prior plan is a plan sponsored by us which was replaced by this plan within 60 days. You are considered covered under the prior plan if you:

1. were covered under the prior plan on the date that plan terminated;
2. properly enrolled for coverage within 31 days of this plan's Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face. See also Orthognathic.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Prudent Buyer Plan: a term associated with a network product owned by Anthem Blue Cross.

Psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

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

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

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

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

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility chapter of this document.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on helping individual attain certain functions that they never have acquired. See also the definition of Habilitation.

See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy, Habilitation, Pulmonary Rehabilitation and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level.
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions or self-payments. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

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

Retiree: a former employee of the County of Sonoma who meets the eligibility requirements outlined in the Eligibility chapter of this document.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are a Maximum Allowed Amount.

Second Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing surgery or receiving a medical service.

Service Area: The geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPO or EPO. See the chapter on Medical Networks for additional information.

Severe mental disorders include severe mental illness as specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia. "Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one

or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Education Code Section 7570).

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Special care units are special areas of a hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation. (Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).)

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and acts under the direction of a Physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Spouse: An employee's or retiree's Spouse means a person of the **opposite gender or same gender** who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan may require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union, or a divorced former Spouse of an employee or retiree, a common law marriage, or a spouse of a Dependent Child.

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

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Subacute care facility is sometimes referred to as a specialty hospital or post acute care, or long term acute care (LTAC) facility.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability subchapter in the chapter on Coordination of Benefits for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit. See also the definition of Tortfeasor.

Subscriber is the person who, by meeting the plan's eligibility requirements for employees and retirees, is allowed to choose membership under this plan for himself or herself and his or her eligible dependents. Such requirements are outlined in the

Eligibility chapter.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Maximum Allowed Amount will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Maximum Allowed Amount
Secondary and additional procedures	50% of the Maximum Allowed Amount per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Maximum Allowed Amount
First site secondary and additional procedures	50% of the Maximum Allowed Amount per procedure
Second site primary and additional procedures	50% of the Maximum Allowed Amount per procedure

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Terminally Ill: means a medical prognosis of six months or less to live, as diagnosed by a Physician.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician or Chiropractor, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant. For further information, see the definition of Occupational, Physical and Speech Therapy.

Tort, Tortfeasor: A civil wrong or injury, typically arising negligent or intentional act of an individual, who is called a tortfeasor. See also the definition of Subrogation.

Totally disabled dependent: is a dependent who has been determined to be disabled by a physician, based on Social Security criteria.

Totally disabled subscriber is a subscriber who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow, peripheral stem cells and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.

See the Schedule of Medical Benefits and the Exclusions chapter for additional information regarding Transplants. See also the Utilization Review chapter of this document for information about precertification requirements for transplantation services.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Claim: See the Claim Filing and Appeal Information chapter for the definition.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Review (UR): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Utilization Review services (sometimes referred to as UR services, Utilization Management services, UM services, or UMR services) are provided by licensed health care professionals employed by the Utilization Review Company operating under a contract with the Plan.

Utilization Review Company: The independent utilization review organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Utilization Review services.

Visit: See the definition of Office Visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be Medically Necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Child Care is described under Wellness/Preventive Care in the Schedule of Medical Benefits.

Year: See Calendar year or Plan year.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do **not** refer to any Dependent of the employee or retiree.

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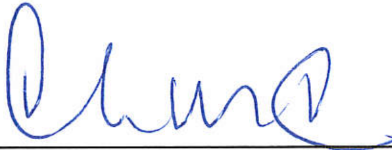
Signature Page

The effective date of the Plan Document for the County of Sonoma Health Plan is January 1, 2020.

It is agreed that the provisions of this document are correct and will be the basis for the administration of the County of Sonoma Health Plan describing the self-funded CHP-EPO Medical Plan and the CHP-PPO Medical Plan.

By this agreement, the County of Sonoma Health Plan is hereby restated and adopted, dated this First day of January, 2020.

For the COUNTY OF SONOMA BOARD OF SUPERVISORS or Designee,



Christina Cramer, Human Resources Director

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