PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND GROUP HEALTH PLAN

Effective July 1, 2024

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INTRODUCTION

This document is a description of Redwood Empire Municipal Insurance Fund Group Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to provide Covered Persons with coverage for certain qualified health expenses.

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You must promptly give the Plan Administrator notice of any claim you have against anyone else, including an insurer, which involves benefits you have received under the Plan. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan. This recovery may be up to the entire amount you recover from third parties, and will not be reduced for attorney's fees or expenses incurred by you in obtaining this recovery. You should review the Program Policies and Procedures, incorporated herein by reference, for the full details of the Plan subrogation rights and obligations.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

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

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

For Plan Years that begin on or after July 1, 2015, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, Pre-authorization or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

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

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will

be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

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

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

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

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

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

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

Defined Terms. Defines those Plan terms that have a specific meaning.

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

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

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

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim arising out of an accidental illness or injury, including but not limited to worker's compensation claims.

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

Non-Assignment: The Plan does not recognize assignments of rights or benefits to any third parties, including medical providers. Although the Plan may make payments directly to providers in the interests of convenience to an Enrolled Member, such payments do not make a provider an assignee or otherwise confer on the provider any rights under the Plan, including any right to claim any breach of fiduciary duty. This provision does not prohibit an Enrolled Member from designating any individual to act on their behalf, but will not confer or transfer to that person any rights or benefits.

Notice re U.S. Code §1557 Compliance –
Discrimination is Against the Law

Redwood Empire Municipal Insurance Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Redwood Empire Municipal Insurance Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Redwood Empire Municipal Insurance Fund:

1. 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)

2. 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 Redwood Empire Municipal Insurance Fund.

If you believe that Redwood Empire Municipal Insurance Fund 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:

Redwood Empire Municipal Insurance Fund
2330 E. Bidwell Street, Suite 150
Folsom, CA 95630
(707) 938-2388 x2
Fax Number: 1-707-938-0374
Email address: anortham@cira-jpa.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Redwood Empire Municipal Insurance Fund 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 OCR 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-442-7247
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag 1-800-442-7247
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-442-7247
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-442-7247

SUMMARY OF BENEFITS

Verification of Eligibility (800) 442-7247

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

MEDICAL BENEFITS

All benefits described in this Summary are percentages paid by the Plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are based on the Recognized Charges, with the exception of certain inpatient care in a network Hospital, emergency room care, or as otherwise required under applicable law; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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

Note: The following is a partial list of services that generally must be pre-authorized or reimbursement from the Plan may be reduced or denied.

Autism Treatment (effective until February 1, 2023)
Applied Behavioral Analysis Therapy (effective until February 1, 2023)
Air Ambulance for Non-Emergent Transport
All Bariatric Procedures
Certain Prosthetics
Diagnostics, including:

- **AmniSure® ROM Test**
- **Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening**
- **Genetic testing for cancer susceptibility**
- **Genetic testing for Inherited Peripheral Neuropathies**
- **Genetic testing for PTEN Hamartoma Tumor Syndrome**
- **High technology radiology services such as MRI, MRA, MEG, PET, CAT, CTA, MRS, CT/PT, SPECT, ECHO cardiology, and some nuclear technology services**
- **Myocardial sympathetic innervations imaging with or without SPECT**
- **Thyroid Fine Needle Aspirate Molecular Markers**

Facility Based Substance Abuse/Mental Disorder treatments
Foot Orthotics
Home Health Care
Infusion Therapy
Inpatient Hospitalizations

- **Elective Admissions**
- **OB Related Medical Stay (OB complications, Excludes childbirth)**
- **Newborn Stays beyond Mother (NICU)**
- **Inpatient Skilled Nursing Facility**
- **Rehabilitation Facility Admissions**
- **Organ, Bone Marrow, and Stem Cell Transplants**

Outpatient surgical procedures and treatments
Rehabilitation services beyond stated Plan limits
Sex Change/Transgender Surgical Procedures

Please see the Cost Management section in this booklet for details.

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

Failure to obtain pre-authorization for a service requiring pre-authorization under the terms of the Plan may result in a reduction of coverage or total denial of coverage of the service by the Plan. The list of services provided above is a partial list. For further details on how to determine if a service requires pre-authorization, see the Cost Management section of this booklet.

PROVIDER NETWORK STATUS

This Plan has entered into an agreement with certain Hospitals, Physicians, Centers of Medical Excellence (CME), and Blue Distinction Centers for Specialty Care (BDCSC), and other health care providers and facilities, which are called Network Providers. Services received from a Network Provider are also referred to as "in-network." Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher coinsurance percentage for services obtained from Network Providers.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider (also referred to as an "out-of-network" provider) is used, except in special circumstances, such as those explained in the Surprise Medical Bills Notice and described below. In most cases it is the Covered Person's choice as to which Provider to use. Terms of agreements that allow Plan Access to Network Providers and other discounts may differ from provisions of the Plan and will be honored by the Plan as required.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

- If a Covered Person has obtained an authorized out of network referral to a Non-Network provider.
- If a Covered Person has an Emergency Medical Condition requiring immediate care.
- If a Covered Person requires emergency ambulance transportation.
- If a covered person has no choice of a Network Provider and receives services by a Non-Network Provider at an in-network facility.
- If a Covered Person is a new member who enrolled in this plan as a result of the group changing health plans, and the Covered Person is receiving services for an acute, serious, or chronic mental or nervous disorder from a Non-Network Provider, the Covered Person may be able to continue the course of treatment with the Non-Network Provider for a reasonable period of time prior to transferring to a Network Provider.
- If a Covered Person is a continuing care patient of a provider or facility which ceases to be a Network Provider as described in the Continuity of Care after Termination of Provider section below.
- As otherwise required by applicable law.

Your provider network publishes a directory of Network Providers. The directory lists all Network Providers in your area, including health care facilities such as Hospitals and skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number

listed on your ID card or you may write to us and ask us to send you a directory. You may also view the directory or search for a Network Provider using the "Provider Finder" function on our website. The listings include the credentials of Network Providers such as specialty designations and board certification. If you use a Non-Network Provider based on a misrepresentation in the Provider Finder that the provider was a Network Provider, the Plan will process and pay the claim as if the provider was in-network to the extent you relied on such misrepresentation, in accordance with applicable law.

To receive Network benefits as indicated in the below Summary of Benefits for your coverage option, you **must** choose Network Providers for all care (with specific, limited exceptions as noted in this Plan Document, such as those explained in the Surprise Medical Bills Notice and described above). If you choose to obtain services from a Non-Network Provider or facility, then the Plan will pay for any Covered Services at the Non-Network benefit level (if any) indicated in the below Summary of Benefits for your elected plan design, and you will be responsible for paying any additional amount to the provider.

As explained in the Surprise Medical Bills Notice below, please note that Non-Network Providers and facilities are generally permitted to "balance bill" covered persons. This means that a covered person may be required to pay the difference between what the provider charges for a service and what the Plan agreed to pay for that service (including amounts paid from the Plan and from your cost share amount). In many situations, this difference could be significant.

You should not receive balance bills from Non-Network Providers and facilities (including independent freestanding emergency departments) for the provision of Emergency Services, air ambulance providers, or certain Non-Network Providers rendering services in Network facilities. **In certain situations, a Non-Network Provider may ask for your consent to balance bill. You are never required to consent to balance billing in those situations. If you consent, you may receive a balance bill.** (See full discussion of your balance billing protections under the No Surprises Act in the Surprise Medical Bills Notice below.)

Surprise Medical Bills - Your Rights and Protections

When you get Emergency Services or get treated by an out-of-network provider at an in-network hospital or Ambulatory Surgical Center, you are protected from surprise billing or balance billing.

This notice describes your rights under the No Surprises Act. This notice is not intended to expand those rights. To the extent there is any discrepancy between the content of this notice and the No Surprises Act, the No Surprises Act will control. This notice is effective as of January 1, 2022.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract to be a part of the Plan's network. These providers and facilities are also sometimes referred to as "non-network", "non-participating", or "non-preferred" providers and facilities. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services

If you have an Emergency Medical Condition and get Emergency Services from an out-of-network provider or facility, the most the provider or facility may bill you is your Plan's in-network cost sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at an in-network hospital or Ambulatory Surgical Center, out-of-network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the Plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Plan will pay out-of-network providers and facilities directly.

- The Plan generally must:

- Cover Emergency Services without requiring you to get approval for services in advance (pre-certification or prior authorization).
- Cover Emergency Services by out-of-network providers.
- Base what you owe the provider or facility (cost sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for Emergency Services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Claims Administrator at (800) 442-7247 or the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

MAXIMUM ALLOWABLE AMOUNT

Network Providers

Covered Services provided by Network Providers are reimbursed based on the Maximum Allowable Amount defined in the provider network agreement. Members are not responsible for Covered Charges in excess of the Maximum Allowable Amount.

If you go to a Hospital which is a Network Provider you should not assume all providers in that Hospital are also Network Providers. To receive the greater benefits afforded when Covered Services are provided by a Network Provider, you should request that all your provider services (such as services by an anesthesiologist) be performed by Network Providers whenever you enter a Hospital.

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

If you do receive services from a Non-Network Provider at an in-network Hospital or Ambulatory Surgical Center, you may be eligible for certain protections as described in the Surprise Medical Bills Notice

Non-Network Providers

Services from Non-Network Providers may or may not be covered depending on the terms listed in your benefit summary. In some plans, services provided by Non-Network Providers will only be covered for Emergency Services, Urgent Care, with an Authorized Referral or as otherwise required by law.

Covered Services from a Non-Network Provider are paid according to the plan's determination of a Maximum Allowable Amount based on one of the following: the Non-Network Provider rate or fee for your plan; an amount negotiated by us or a third party vendor which has been agreed to by the Non-Network Provider or other health care provider; an amount derived from the total charges billed by the Non-Network provider; an amount based on the plan's determination of Recognized Charge; or another amount determined in accordance with law. Members are always responsible for Covered Charges in excess of the Maximum Allowable Amount when using Non-Network Providers for non-emergency services, except as described in the Surprise Medical Bills Notice.

Members who receive Emergency Services from Non-Network Providers are not responsible for Covered Charges in excess of the Maximum Allowable Amount.

Members who receive non-emergency services from Non-Network providers as an inpatient at a Network hospital are not responsible for covered charges in excess of the Maximum Allowable Amount.

EPO Plans: Diagnostic laboratory and surgical pathology test services performed by a Non-Network Provider as the result of a referral by a Network Provider will be considered covered services for members on an EPO plan. Covered Services are paid according to the plan's determination of an Maximum Allowable Amount based on one of the following: the Non-Network Provider rate or fee for your plan; an amount negotiated by us or a third party vendor which has been agreed to by the Non-Network Provider or other health care provider; an amount derived from the total charges billed by the Non-Network Provider; an amount based on the Plan's determination of Recognized Charge; or another amount determined in accordance with law. Members are always responsible for Covered Charges in excess of the Maximum Allowable Amount when using Non-Network Providers for non-emergency services, except as described in the Surprise Medical Bills Notice.

The Claims Administrator has the sole and absolute discretion to determine the Maximum Allowable Amount for a particular service, supply, or procedure, utilizes its own internal coverage guidelines to do so, and expressly disavows use of usual, customary, and reasonable standards.

Authorized Referrals

In some circumstances we may authorize you to receive services provided by a Non-Network Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the covered service you receive from a Non-Network Provider. It is your responsibility to ensure that we have been contacted. Under certain circumstances we may retroactively authorize referrals due to medical necessity. Retroactive referrals will be restricted to services rendered within six (6) months prior to request for authorization. If we authorize you to receive services provided by a Non-Network Provider, you may still be liable for the difference between the Maximum Allowable Amount and the Non-Network Provider's charge. Please call the customer service telephone number on your ID card for Authorized Referral information or to request authorization.

Clinical Trials

The Maximum Allowable Amount for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a Network Provider.

Medicare Primary

If Medicare is the primary payor, the Maximum Allowable Amount does not include any charge:

(1) By a Hospital, in excess of the approved amount as deemed by Medicare; or

(2) By a Physician who is a Network Provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

(3) By a physician who is a Non-Network Provider or other health care provider who accepts Medicare assignment, in excess of lesser of the Maximum Allowable 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 Allowable Amount stated above, or the limiting charge as determined by Medicare.

MEMBER COST SHARE

For certain Covered Services, and depending on your plan design, you may be required to pay all or a part of the Maximum Allowable Amount as your cost share amount (Deductibles, Copayments or Coinsurance). Please see your plan's Summary of Benefits for your cost share responsibilities and limitations, or call the customer service telephone number on your ID card to learn how this plan's benefits or cost share amounts may vary by the type of provider you use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a Network Provider, Non-Network Provider or other health care provider. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

Deductibles/Copayments/Coinsurance payable by Covered Persons (See additional information under Medical Benefits section below)

Plan Year Deductibles

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. A deductible is an amount of money that is paid once per Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each July 1st, a new deductible amount is required.

Copayment

A copayment is a fixed amount of money that is paid each time a particular service is used. There may be copayments on some services and not on other services Copayments are listed in the Summary of Benefits.

Coinsurance

Coinsurance is the Covered Person's share of the cost for Covered Services which is a percentage of the Allowable Amount. Coinsurance is paid after the deductible has been met. Coinsurance is listed in the Summary of Benefits.

OUT OF POCKET MAXIMUM LIMIT

The out of pocket maximum limit is the most you could pay during a Plan Year for your share of the cost of Covered Services. A Covered Person may have separate out of pocket maximum limits for medical services and for prescription benefits. Once a Covered Person meets the Out of Pocket Maximum Limit, covered charges will be payable at 100% (except for any charges excluded from the Out of Pocket Maximum Limit for the rest of the Plan year).

Meeting the Out of Pocket Maximum Limit

The Plan deductibles, copayments and coinsurance amounts are included in the out of pocket maximum limit. If, after you have met your deductible, you pay copayments and coinsurance equal to your out of pocket maximum limit during the Plan Year, you will no longer be required to make copayments or coinsurance payments for additional Covered Services or supplies during the remainder of that Plan Year, except as specifically stated under Charges Which Do Not Apply Toward the Out Of Pocket Maximum Limit below.

Internal Coverage Guidelines

The Claims Administrator may utilize internal coverage guidelines to determine Allowable Amounts, to determine whether a particular charge or service is Medically Necessary, or for other purposes in its capacity as Claims Administrator. These internal coverage guidelines are expressly incorporated into this document by this reference and are binding.

Charges Which Do Not Apply Toward the Out of Pocket Maximum Limit

Except as required by law, the following charges will not be applied to the out of pocket maximum limit:

- Charges which are not covered under this plan;
- Charges which exceed the Maximum Allowable Amount.

- For the Exclusive Provider Organization (“EPO”) plans: Charges incurred for services and supplies from a Non-Network Provider without an Authorized Referral unless in connection with an Emergency Medical Condition or Urgent Care.

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR		
Per Covered Person	$250	
Per Family Unit	$750	
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Per Covered Person	$3,400	
Two Party	$6,800	
Per Family Unit	$10,000	
The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%, unless required by law: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Percentage Payable – unless otherwise stated.	100% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	Covered Services from non-contracted (out of network) providers are not covered except in cases of emergency, authorized out of network referral or as required by law. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	100% after deductible	Not covered
Acupuncture Services	100% after deductible; 12 visits Plan Year maximum	Not covered
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	100% after $50 copayment per date of service and deductible	Not covered
Ambulance Service - Pre-authorization is required for non-emergent transport.	100% after deductible	100% after deductible
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures – Facility	100% after deductible	Not covered
Bariatric Surgical Procedures – Physician	100% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges– Coverage is available when the closest BDCSC and CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	100% after deductible	Not covered
Cellular and Gene Therapies	100% after deductible†	Not covered

Diabetes Education	100% after $25 copayment; deductible waived	Not covered

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Diabetes Supplies (such as insulin pumps and glucometers)	100% after deductible	Not covered
Dialysis	100% after deductible	Not covered
Durable Medical Equipment - Pre-authorization is required.	100% after deductible	Not covered
Emergency Room Visit – Including professional services	100% after $150 copayment and deductible; Copayment waived if admitted.	100% after $150 copayment and deductible; Copayment waived if admitted.
Foot Orthotics – Pre-authorization Required	100% after deductible	Not covered
Hearing Aids	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	100% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	Not covered
Hospice Care	100%; deductible waived	Not covered
Bereavement Counseling	100%; deductible waived	Not covered
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	100% after deductible	Not covered
Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures.	100% after deductible	Not covered
Outpatient Services - Pre-authorization is required for certain services.	100% after deductible	Not covered
Infusion Therapy (Pre-authorization required)	100% after deductible	Not covered
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	100% after deductible	Not covered
Lab & X-ray – includes pre-admission testing.	100% after $10 copayment per date of service and deductible	Not covered
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Not Covered
Mental Disorders		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	100% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	100% after deductible	Not covered
Office Setting	100% after $25 copayment; deductible waived	Not covered

Nutritional Evaluation and Counseling – coverage for eating disorders only	100% after deductible	Not covered
SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	100% after deductible; $30,000 maximum per transplant	Not covered
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	100% after deductible	Not covered
Office visits	100% after $25 copayment; deductible waived	Not covered
Specialist Office visit	100% after $35 copayment; deductible waived	Not covered
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	100% after deductible	Not covered
Second Surgical Opinion	100% after $25 copayment or $35 specialist copayment; deductible waived	Not covered
Surgery (Inpatient and Outpatient)	100% after deductible	Not covered
Assistant Surgeon and Anesthesiologists	100% after deductible	Not covered
Allergy injections, serum and testing	100% after deductible	Not covered
Contraceptive Methods	100%; deductible waived	Not covered
Pregnancy		
Prenatal visits	100%; deductible waived	Not covered
Postnatal visits	100% after $25 copayment; deductible waived	Not covered
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Not covered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	Not covered
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	100% after deductible	Not covered
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	100% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	Not covered

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

†Only covered as described in the Cellular or Gene Therapy Coverage Section below.

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Sex Change / Transgender Surgical Procedures - Pre- authorization is required.	100% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required.	100% after deductible; 100 days Plan Year maximum	Not covered
Speech Therapy	100% after deductible	Not covered
Spinal Manipulation / Chiropractic	100% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	Not covered
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	100% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	100% after deductible	Not covered
Office Setting	100% after $25 copayment; deductible waived	Not covered
Urgent Care – includes physician services	100% after $25 copayment; deductible waived	100% after $25 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	Not covered
Male	100% after deductible	Not covered
Wigs	Not covered	Not covered

PRESCRIPTION DRUG BENEFIT SUMMARY EPO 250

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number. Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $10 copayment	100% of Maximum Allowable Amount after $10 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $25 copayment	100% of Maximum Allowable Amount after $25 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	100% of Maximum Allowable Amount after $38 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 – Specialty Pharmacy - must be obtained through Specialty Mail Order Service. 30-day supply only.		
Generic Specialty	100% after $150 Copayment	Not Covered
Non-Generic Specialty	20% coinsurance (member cost share can be reduced by availability of and participation in Plan copay assistance programs)	Not Covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS BLUECARD PPO 250

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are combined.		
Per Covered Person	$250	
Per Family Unit	$750	
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$3,400	$4,400
Two Party	$6,800	$8,800
Per Family Unit	$10,000	$14,800
The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%, unless required by law: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	100% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for Covered Services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	100% after deductible	70% after deductible
Acupuncture Services	100% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) – Pre-authorization is required.	100% after $50 copayment per date of service deductible	70% after deductible; $800, maximum per procedure
Ambulance Service – Pre-authorization is required for non-emergent transport.	100% after deductible	100% after deductible; .
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	100% after deductible	Not covered
Bariatric Surgical Procedures - Physician	100% after deductible	Not covered

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC or CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	80% after deductible	70% after deductible
Cellular and Gene Therapies	100% after deductible†	Not covered
Diabetes Education	100% after $25 copayment; deductible waived	70% after deductible
Diabetes Supplies (such as insulin pumps and glucometers)	100% after deductible	70% after deductible
Dialysis	100% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	100% after deductible	70% after deductible
Emergency Room Visit – Including professional services	100% after $150 copayment and deductible; Copayment waived if admitted.	100% after $150 copayment and deductible; Copayment waived if admitted.
Foot Orthotics – Pre-authorization is required	100% after deductible	70% after deductible
Hearing Aids	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care – Pre-authorization is required.	100% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	100%; deductible waived	70% after deductible
Bereavement Counseling	100%; deductible waived	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	100% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers.
Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures.	100% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services – Pre-authorization is required for certain services.	100% after deductible	70% after deductible
Infusion Therapy Pre-authorization is required.	100% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	100% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	100% after $10 copayment per date of service and deductible	70% after deductible

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's Semiprivate room rate - Pre- authorization is required; waived for emergencies.	100% after deductible	70% after deductible Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	100% after deductible	70% after deductible
Office Setting	100% after $25 copayment; deductible waived	70% after deductible
Nutritional Evaluation and Counseling – coverage for eating disorders only	100% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	100% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges– benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	100% after deductible	70% after deductible
Office visits	100% after $25 copayment; deductible waived	70% after deductible
Specialist Office visits	100% after $35 copayment; deductible waived	70% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	100% after deductible	70% after deductible
Second Surgical Opinion	100% after $25 copayment or $35 specialist copayment; deductible waived	70% after deductible
Surgery (Inpatient and Outpatient)	100% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	100% after deductible	70% after deductible
Allergy injections, serum and testing	100% after deductible	70% after deductible
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	70% after deductible
Postnatal visits	100% after $25 copayment; deductible waived	70% after deductible

BLUECARD PPO 250

COVERED CHARGES	WHAT THE PLAN PAYS NETWORK PROVIDERS	WHAT THE PLAN PAYS NON-NETWORK PROVIDERS
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics - Pre-authorization is required for certain prosthetics	100% after deductible	70% after deductible
Rehabilitation – includes Physical, and Occupational Therapies. Additional visits are allowed if Medically Necessary.	100% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required.	100% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate - Pre-authorization is required.	100% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	100% after deductible	70% after deductible
Spinal Manipulation Chiropractic	100% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre- authorization is required; waived for emergencies.	100% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	100% after deductible	70% after deductible
Office Setting	100% after $25 copayment; deductible waived	70% after deductible
Urgent Care - includes physician services	100% after $25 copayment; deductible waived	100% after $25 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	100% after deductible	70% after deductible
Wigs – after chemotherapy	Not covered	Not covered

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

†Only covered as described in the Cellular or Gene Therapy Coverage Section below.

PRESCRIPTION DRUG BENEFIT SUMMARY BLUECARD PPO 250

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $10 copayment	100% of Maximum Allowable Amount after $10 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $25 copayment	100% of Maximum Allowable Amount after $25 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	100% of Maximum Allowable Amount after $38 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 – Specialty Pharmacy - must be obtained through Specialty Mail Order Service. 30-day supply only.		
Generic Specialty	100% after $150 Copayment	Not Covered
Non-Generic Specialty	20% coinsurance (member cost share can be reduced by availability of and participation in Plan copay assistance programs)	Not Covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR		
Per Covered Person	$500	
Per Family Unit	$1,500	
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Per Covered Person	$3,400	
Two Party	$6,800	
Per Family Unit	$10,000	
The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%, unless required by law. • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Percentage Payable – unless otherwise stated.	90% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	Covered Services from non- contracted (out of network) providers are not covered except in cases of emergency, authorized out of network referral or as required by law. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion - Elective	90% after deductible	Not covered
Acupuncture Services	90% after deductible; 12 visits Plan Year maximum	Not covered
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	90% after deductible	Not covered
Ambulance Service - Pre-authorization is required for non-emergent transport.	90% after deductible	90% after deductible
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	90% after deductible	Not covered
Bariatric Surgical Procedures - Physician	90% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	90% after deductible	Not covered
Cellular and Gene Therapies	100% after deductible†	Not covered

Diabetes Education	100% after $30 copayment; deductible waived	Not covered

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Diabetes Supplies (such as insulin pumps and glucometers)	90% after deductible	Not covered
Dialysis	90% after deductible	Not covered
Durable Medical Equipment - Pre-authorization is required.	90% after deductible	Not covered
Emergency Room Visit – Including professional services	90% after $150 copayment and deductible; copayment waived if admitted	90% after $150 copayment and deductible; copayment waived if admitted
Foot Orthotics– Pre-authorization Required	90% after deductible	Not covered
Hearing Aids	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	90% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	Not covered
Hospice Care	100%; deductible waived	Not covered
Bereavement Counseling	100%; deductible waived	Not covered
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	90% after deductible	Not covered
Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures.	90% after deductible	Not covered
Outpatient Services - Pre-authorization is required for certain services.	90% after deductible	Not covered
Infusion Therapy (Pre-authorization required)	90% after deductible	Not covered
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	90% after deductible	Not covered
Lab & X-ray – includes pre-admission testing.	90% after deductible	Not covered
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Not Covered
Mental Disorders		
Inpatient - the facility's semiprivate room rate. Pre- authorization is required; waived for emergencies.	90% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	90% after deductible	Not covered
Office Setting	100% after $30 copayment; deductible waived	Not covered

Nutritional Evaluation and Counseling – coverage for eating disorders only	90% after deductible	Not covered

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	90% after deductible; $30,000 maximum per transplant	Not Covered
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	90% after deductible	Not covered
Office visits	100% after $30 copayment; deductible waived	Not covered
Specialist Office visits	100% after $40 copayment; deductible waived	Not covered
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	90% after deductible	Not covered
Second Surgical Opinion	100% after $30 copayment or $40 specialist copayment; deductible waived	Not covered
Surgery (Inpatient and Outpatient)	90% after deductible	Not covered
Assistant Surgeon and Anesthesiologists	90% after deductible	Not covered
Allergy injections, serum and testing	90% after deductible	Not covered
Contraceptive Methods	100%; deductible waived	Not covered
Pregnancy		
Prenatal visits	100%; deductible waived	Not covered
Postnatal visits	100% after $30 copayment; deductible waived	Not covered
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Not covered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	Not covered
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	90% after deductible	Not covered
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	90% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	Not covered

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Sex Change / Transgender Surgical Procedures - Pre- authorization is required.	90% after deductible	Not Covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required	90% after deductible; 100 days Plan Year maximum	Not covered
Speech Therapy	90% after deductible	Not covered
Spinal Manipulation / Chiropractic	90% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	Not covered
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	90% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	90% after deductible	Not covered
Office Setting	100% after $30 copayment; deductible waived	Not covered
Urgent Care - includes physician services	100% after $30 copayment; deductible waived	100% after $30 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	Not covered
Male	90% after deductible	Not covered
Wigs	Not covered	Not covered

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

†Only covered as described in the Cellular or Gene Therapy Coverage Section below.

PRESCRIPTION DRUG BENEFIT SUMMARY EPO 500

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $35 copayment	100% of Maximum Allowable Amount after $35 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	100% of Maximum Allowable Amount after $23 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	100% of Maximum Allowable Amount after $53 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 – Specialty Pharmacy - must be obtained through Specialty Mail Order Service. 30-day supply only.		
Generic Specialty	100% after $150 Copayment	Not Covered
Non-Generic Specialty	20% coinsurance (member cost share can be reduced by availability of and participation in Plan copay assistance programs)	Not Covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are not combined.		
Per Covered Person	$500	$1,000
Per Family Unit	$1,500	$3,000
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$3,400	$8,400
Two Party	$6,800	$16,800
Per Family Unit	$10,000	$26,800
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%, unless required by law: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	80% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for Covered Services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	80% after deductible	70% after deductible
Acupuncture Services	80% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	80% after deductible	70% after deductible; $800 maximum per procedure
Ambulance Service - Pre-authorization is required for non-emergent transport.	80% after deductible	80% after deductible;
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	80% after deductible	Not covered

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Bariatric Surgical Procedures - Physician	80% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC or CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	80% after deductible	70% after deductible
Cellular and Gene Therapies	100% after deductible†	Not covered
Diabetes Education	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Diabetes Supplies (such as insulin pumps and glucometers)	80% after deductible	70% after deductible
Dialysis	80% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	80% after deductible	70% after deductible
Emergency Room Visit – Including professional services	80% after $150 copayment and deductible; Copayment waived if admitted	80% after $150 copayment and deductible; Copayment waived if admitted
Foot Orthotics - Pre-authorization is required.	80% after deductible	70% after deductible
Hearing Aids	80% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	80% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	80% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	100%; deductible waived	70% after deductible
Bereavement Counseling	100%; deductible waived	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	80% after deductible	70% after deductible Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures.	80% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Infusion Therapy (Pre-authorization is required)	80% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	80% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	80% after deductible	70% after deductible
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	80% after deductible	70% after deductible. Failure to obtain pre- authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Office Setting	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Nutritional Evaluation and Counseling – coverage for eating disorders only	80% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	80% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	80% after deductible	70% after deductible
Office visits	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Specialist Office Visits	100% after $40 copayment; deductible waived	100% after $60 copayment; deductible waived
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	80% after deductible	70% after deductible
Second Surgical Opinion	100% after $30 copayment or $40 specialist copayment; deductible waived	100% after $50 copayment or $60 specialist copayment; deductible waived
Surgery (Inpatient and Outpatient)	80% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	80% after deductible	70% after deductible
Allergy injections, serum and testing	80% after deductible	70% after deductible

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	100% after $50 copayment; deductible waived
Postnatal visits	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	80% after deductible	70% after deductible
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	80% after deductible; 24 visits Plan Year maximum with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required	80% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required	80% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	80% after deductible	70% after deductible
Spinal Manipulation / Chiropractic	80% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre- authorization is required; waived for emergencies.	80% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Office Setting	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Urgent Care – includes physician services	100% after $30 copayment; deductible waived	100% after $30 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	80% after deductible	70% after deductible
Wigs – after chemotherapy	Not covered	Not covered

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

†Only covered as described in the Cellular or Gene Therapy Coverage Section below.

PRESCRIPTION DRUG BENEFIT SUMMARY PPO 500

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $35 copayment	100% of Maximum Allowable Amount after $35 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	100% of Maximum Allowable Amount after $23 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	100% of Maximum Allowable Amount after $53 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 – Specialty Pharmacy - must be obtained through Specialty Mail Order Service. 30-day supply only.		
Generic Specialty	100% after $150 Copayment	Not Covered
Non-Generic Specialty	20% coinsurance (member cost share can be reduced by availability of and participation in Plan copay assistance programs)	Not Covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS HDHP 1600

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

SUMMARY OF BENEFITS HDHP 1600		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are combined.		
Single	$1,600	
Family Unit	$3,200	
For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For family coverage, the Aggregate Deductible must be met as a Family Unit before any money is paid by the Plan for any Covered Charge.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of- Pocket amounts are combined.		
Single	$5,000	
Family Unit	$10,000	
For single coverage, the Plan will pay the designated percentage of Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise. The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches single covered out-of-pocket costs, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Plan Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%, unless required by law: • Cost containment penalties • Amounts over the Maximum Allowable Amount		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	90% after deductible for Covered Services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for Covered Services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts, except as described in the Surprise Medical Bills Notice.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	90% after deductible	70% after deductible
Acupuncture Services	90% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	90% after deductible	70% after deductible; $800 maximum per procedure

SUMMARY OF BENEFITS HDHP 1600		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Ambulance Service - Pre-authorization is required for non-emergent transport.	90% after deductible	90% after deductible; .
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	90% after deductible	Not covered
Bariatric Surgical Procedures - Physician	90% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges– Coverage is available when the closest CME is 50 miles or more from the Covered Person's residence.	100% after deductible; $3,000 maximum per surgery	
Blood	90% after deductible	70% after deductible
Cellular and Gene Therapies	100% after deductible†	Not covered
Diabetes Education	90% after deductible	70% after deductible
Diabetes Supplies (such as insulin pumps and glucometers)	90% after deductible	70% after deductible
Dialysis	90% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	90% after deductible	70% after deductible
Emergency Room Visit – Including professional services	90% after deductible	90% after deductible
Foot Orthotics - Pre-authorization is required.	90% after deductible	70% after deductible
Hearing Aids	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	90% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	90% after deductible	70% after deductible
Bereavement Counseling	90% after deductible	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	90% after deductible	70% after deductible
Ambulatory/Outpatient Surgery Facilities.* Pre-authorization is required for certain procedures.	90% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services - Pre-authorization is required for certain services.	90% after deductible	70% after deductible
Infusion Therapy (Pre-authorization require)	90% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies

SUMMARY OF BENEFITS HDHP 1600		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	90% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	90% after deductible	70% after deductible
LiveHealth Online telemedicine: Medical & Behavioral Health	90% after deductible**	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's semiprivate room rate. Pre-authorization is required.	90% after deductible	70% after deductible
Outpatient - Pre-authorization is required for certain services.	90% after deductible	70% after deductible
Office Setting	90% after deductible	70% after deductible
Nutritional Evaluation and Counseling – coverage for eating disorders only	90% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	90% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100% after deductible; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	90% after deductible	70% after deductible
Office visits	90% after deductible	70% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	90% after deductible	70% after deductible
Second Surgical Opinion	90% after deductible	70% after deductible
Surgery (Inpatient and Outpatient)	90% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	90% after deductible	70% after deductible
Allergy injections, serum and testing	90% after deductible	70% after deductible
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	70% after deductible
Postnatal visits	90% after deductible	70% after deductible
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered

*If Emergency Services are provided at an Ambulatory Surgical Center, the Plan's terms and conditions for coverage (including cost sharing and whether prior authorization applies) may be different than what is shown above, to conform with the requirements of the No Surprises Act.

**To the extent permitted by federal guidance, telemedicine visits may be covered without any cost sharing without impacting an individual's eligibility to contribute to a Health Savings Account.

†Only covered as described in the Cellular or Gene Therapy Coverage Section below.

PRESCRIPTION DRUG BENEFIT SUMMARY HDHP 1600

SUMMARY OF BENEFITS HDHP 1600		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Prescription Drug Benefit In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network- participating pharmacy, will be covered at 100% with no deductible or co-insurance required. **Dispense As Written (DAW) Penalty.** If the Covered Person or the Covered Person's doctor requests a brand-name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after deductible and $10 copayment	100% after deductible and $10 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after deductible and $25 copayment	100% after deductible and $25 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after deductible and $50 copayment	100% after deductible and $50 copayment; plus all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after deductible and $20 copayment	100% after deductible and $20 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after deductible and $50 copayment	100% after deductible and $50 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after deductible and $100 copayment	100% after deductible and $100 copayment; plus all charges in excess of the Maximum Allowable Amount
Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after deductible and $20 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after deductible and $50 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after deductible and $100 copayment	Not covered
Tier 4 – Specialty Pharmacy - must be obtained through Specialty Mail Order Service. 30-day supply only. Generic Specialty Non-Generic Specialty	 100% after deductible and $150 Copayment 20% coinsurance after deductible	 Not Covered Not Covered

	(member cost share can be reduced by availability of and participation in Plan copay assistance programs)	
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered

SUMMARY OF BENEFITS HDHP 1600		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Prosthetics Pre-authorization is required for certain prosthetics	90% after deductible	70% after deductible
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	90% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required.	90% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100% after deductible; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required.	90% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	90% after deductible	70% after deductible
Spinal Manipulation / Chiropractic	90% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate. Pre- authorization is required.	90% after deductible	70% after deductible
Outpatient - Pre-authorization is required for certain services.	90% after deductible	70% after deductible
Office Setting	90% after deductible	70% after deductible
Urgent Care – includes physician services	90% after deductible	90% after deductible
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	90% after deductible	70% after deductible
Wigs – after chemotherapy	90% after deductible	70% after deductible

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant may contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees, as follows:

(1) For Employees: Employees are eligible to enroll if the Employee qualifies for medical coverage as defined in the Participating Employer's policies, the Participating Employer's Participation Agreement and/or Memorandum of Understanding (MOU) with the Participating Employer. The usual residence of the Employee is within the State of California. The Plan does not allow dual coverage for Employees working for the same Employer. Any person covered on this Plan as an Employee cannot also be covered as a Dependent.

(2) For Retired Employees: Covered Employees who terminate employment due to retirement and who meet both the Participating Employer's definition of a retired Employee and the REMIF minimum 10 year service requirement may be entitled to retiree coverage under this Plan. Please check with the Human Resources Department of the applicable Employer to determine whether or not the Employer offers retiree health coverage and whether the Employee meets the eligibility guidelines for retiree health coverage. Retiree coverage under this Plan is not offered to Retirees who retire at the age of 65 or older, but such Retirees may be entitled to coverage under the REMIF Medicare Supplement Plan if the Participating Employer makes such coverage available to its Retirees and the Retirees otherwise satisfy the eligibility requirements set forth by the Participating Employer and REMIF in order to participate in that plan. The Employee may also be entitled to COBRA continuation of coverage. Eligibility for COBRA is based on Federal law and is discussed under the section entitled Continuation Coverage Rights Under COBRA in this booklet.

The Plan does not allow dual coverage for Retirees who retired from the same Employer. Any person covered on this Plan as a Retiree cannot also be covered as a Dependent.

For Dependents of Eligible Retirees: A dependent who is under age 65 may remain eligible for this plan as long as the Retiree is under age 65, or, if age 65 or over, the Retiree enrolls in and remains covered by the REMIF Medicare Supplement Plan.

Covered Retirees who attain age 65 are no longer eligible for retiree coverage under this Plan. Please check with the Human Resources Department of the applicable Employer to determine whether or not the REMIF Medicare Supplement program is available to the Covered Retiree upon reaching age 65.

For Dependents of Retirees: Covered dependents who have not attained age 65 are eligible for coverage under this Plan. Covered dependents who attain age 65 are no longer eligible for retiree coverage under this Plan. Please check with the Human Resources Department of the applicable Employer to determine whether or not the REMIF Medicare Supplement program is available to a covered dependent when he/she turns 65.

If a covered Retiree returns to active services with a Participating Employer, the Retiree may be eligible to be covered as either an Active Employee or remain covered as a Retiree, but not both.

(3) For an Employee who retires due to a specific disability: An Employee who retires due to a service-connected disability need not meet the REMIF requirement of ten years of service. An Employee who retires from services with a Participating Employer due to a PERS disability retirement (non-safety) or a PERS industrial disability retirement (safety) need not meet the REMIF requirement of ten years of service. However, he or she must have worked the minimum number of years as required by the Participating Employer's labor agreement.

(4) Special eligibility criteria to address COVID-19: Notwithstanding any other Plan provision providing for an earlier termination of coverage, all Employees who were enrolled in the Plan effective March 1, 2020 will remain eligible for continued enrollment in the Plan despite any actively-at-work or minimum-hour requirements during the time that:

(a) the Employee is placed on furlough or reduced-hours furlough by the Employer due to issues related to COVID-19, as determined in the Employer's sole discretion; or

(b) the Employee is absent in order to provide care for an immediate family member or themselves related to COVID-19, or to provide primary care for children where there is no other viable childcare available due to the closure of schools or childcare centers related to COVID-19 precautions, whichever is longer, if so approved by the Employer in its sole discretion.

This special continuation of coverage due to COVID-19 allows the Plan Participants described above to continue to participate in the Plan under the same terms and conditions as if the Plan Participants remained actively employed on a full-time status during such furlough; however, this special extension of coverage shall not exceed one hundred and fifty (150) days (or the end of the month following 150 days if the 150-day period does not end on the end of a month), unless such period of time is extended by the Employer or the Plan Administrator in its sole discretion. To remain enrolled, such Plan Participants must continue to timely make required contributions, as set forth in more detail elsewhere in the Plan. For purposes of this special extension of coverage, a "furlough" shall mean a temporary layoff or involuntary leave without pay, and a "reduced-hours furlough" shall mean a temporary and involuntary reduction in hours with a corresponding reduction in pay. The provisions of this paragraph do not apply to a termination of employment where the Employer has no intention for the Employee to return to work. Furlough and termination of employment determinations are made in the sole discretion of the Employer.

Employees become eligible for coverage in accordance with rules established by the Employer. For specific information about the Employer's eligibility rules for coverage, please contact the Human Resources or Benefits Department of the Employer.

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

(1) A covered Employee's Spouse.

A Spouse is the Covered Employee's Spouse under a legally valid marriage. Spouse does not include any person who is in active service in the armed forces.

(2) For purposes of this Plan, the term Spouse shall also include the employee's Domestic Partner. Domestic Partner is the Covered Employee's Domestic Partner under a valid Declaration of Domestic Partnership filed with the California Secretary of State. Domestic Partners may be same or opposite sex. Domestic Partner does not include any person who is active service in the armed forces.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, Redwood Empire Municipal Insurance Fund, 2330 E. Bidwell Street, Suite 150, Folsom, CA 94530 , (707) 938-2388 x2.

In the event the domestic partnership is terminated, either partner is required to inform the Participating Employer or Redwood Empire Municipal Insurance Fund of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(3) The Spouse of a covered Retiree. The spouse of a Retired Employee remains eligible as long as the Retired Employee continues coverage under a REMIF sponsored plan.

(4) A covered Employee's or Retiree's Child(ren).

An Employee's "Child" includes his natural child, stepchild, child for whom the Employee is the legal guardian, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children of the Domestic Partner, a child for whom the Employee's Domestic Partner is the legal guardian, adopted children or children placed for adoption with the Employee's Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age of 26, coverage will end on the last day of the child's birthday month.

A child for whom the Covered Employee, Spouse or Domestic Partner is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). REMIF must receive legal evidence of the decree.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

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

The child(ren) of a covered Retiree. The dependent child(ren) of a Retired Employee remains eligible as long as the Retired Employee continues coverage under a REMIF sponsored plan.

(5) An unmarried covered Dependent child who reaches the limiting age of 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; any former Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee or Retiree.

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

If both mother and father are Employees, eligible children can be covered as Dependents of the mother or father, or both.

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

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

Other Eligible Class. Any person deemed eligible based on a court order or legal settlement entered into by a Participating Employer if such coverage or equivalent coverage is available at the time of the court order or agreement.

FUNDING

Cost of the Plan. Participating Employers of Redwood Empire Municipal Insurance Fund may share the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee contributions is set by the Participating Employer. The Participating Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee and eligible dependents must enroll for coverage by properly filing a signed enrollment application along with the appropriate payroll deduction authorization. An application is considered properly filed if it is completed, signed, dated, and given to the employer within 31 days from the eligibility date. If any of these steps are not followed, coverage may be denied.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is automatically enrolled in this Plan for 31 days for certain Covered Charges. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the covered parent. For coverage other than nursery care and routine Physician care during the first 31 day period and/or to continue beyond this 31 day period, the Employee must properly submit a completed enrollment form to the Employer within the 31 day period following the child's date of birth. A birth certificate is not required to complete an application. The Plan may at any time require proof of birth to verify eligibility. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs. An application is considered properly filed if it is completed, signed, dated, and given to the employer within 31 days from the child's date of birth. A birth certificate is not required to complete an application. The Plan Administrator may require proof of birth at any time to verify eligibility.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator before, on, or within 31 days after the person becomes eligible for the coverage, either initially or after a permitted Mid-Year Election Event, described in the "Mid-Year Election Events" section below.

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

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" as described in the "Timely Enrollment" provision above. Late Enrollees and their eligible Dependents who are not eligible to join the Plan because of a permitted Mid-Year Election Event may join only during open enrollment.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage will not begin for any Late Enrollee until the start of the subsequent Plan Year (effective the next July 1st for any Late Enrollee who enrolls during an Open Enrollment period).

MID-YEAR ELECTION EVENTS

You may change your election mid-year only if you experience one of the following Mid-Year Election Events:

- Marriage, divorce, legal separation or annulment, registration of a Domestic Partner or dissolution of a domestic partnership;
- The birth, adoption, placement for adoption or legal guardianship of a Child;
- The death of a Dependent;
- You or your Spouse or other eligible Dependent begin or terminate employment, go on strike or are locked out, change worksites, start an FMLA leave of absence, or have any other change in employment status (e.g. full-time to part-time) that affects your or your Spouse's or Dependent's eligibility for coverage under the Plan;
- Your Dependent Child no longer qualifies as an eligible Dependent;
- Changes in the cost of a benefit;
- Significant coverage curtailment;
- Addition of or significant improvement of a benefit option;
- You or your eligible Dependent(s) no longer live or work in a plan's network service area and no other benefit option is available to you or your eligible Dependent(s);

- Benefits are no longer offered by the applicable plan to a class of individuals that covers you or your eligible Dependent(s);

- Termination of your or your Dependent's coverage under Medicare, Medicaid or a State Child Health Insurance Program as a result of a loss of eligibility;

- You or your Dependent become eligible for enrollment in or for a premium assistance subsidy under Medicare, Medicaid or a State Child Health Insurance Program;

- A court order requires you or someone else to cover a Dependent;

- You experience a reduction in hours from more than 30 hours per week, on average, to less than 30 hours per week, on average, followed by enrollment in Health Insurance Marketplace coverage or other qualifying coverage no later than the start of the second full month following the reduction;

- You qualify for an annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day following the termination of coverage under this Plan; or

- A HIPAA Special Enrollment Right, as described in the sections immediately below (see sections entitled "Special Enrollment Rights" and "Special Enrollment Periods and Effective Dates").

Coverage election changes must be consistent with the triggering event. In other words, your election change must be because of and correspond with the triggering event. The Plan Administrator has sole discretion in determining whether an event permits a midyear election change under this Plan.

A request for an election change must be made within 31 days after the date of the Mid-Year Election Event. Generally, coverage will become effective the first of the month following the date you file an election change. In the case of the birth, adoption or placement for adoption of a Child, coverage will be retroactively effective to the date of the birth or the date of the adoption or placement for adoption.

If a court has ordered coverage be provided for a Spouse, Domestic Partner or dependent child under your employee health plan, an application must be filed within 31 days from the date the court order is issued.

If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 31 days after REMIF receives a copy of the court order or of a request from the district attorney, either parent or the person having custody of the child, the employer, or the group administrator.

If a court has ordered that coverage be provided for a Spouse or Domestic Partner, coverage will become effective the first day of the first calendar month following the date the completed enrollment form is received.

If you change your coverage option under this Plan as a part of a mid-year election change in accordance with this section, and if you are covered continuously under this Plan before, during and after the change in coverage option, any amounts allocated to plan accumulators, such as deductibles and out-of-pocket maximums, will be carried over from the former coverage option to the new coverage option such that the Plan Member will get credit for those out-of-pocket expenses already incurred during the Plan Year and will not have to restart accumulators mid-year under the new coverage option.

For additional information on how to make a mid-year election change or on what election changes are allowed for a certain Mid-Year Election Event, please contact the Human Resources coordinator at the

applicable Participating Employer, or the Plan Administrator, Redwood Empire Municipal Insurance Fund, 2330 E. Bidwell Street, Suite 150, Folsom, CA 94530 , (707) 938-2388 x2.

SPECIAL ENROLLMENT RIGHTS

Federal law (HIPAA) provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration for domestic partnership, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, registration for domestic partnership, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Human Resources coordinator at the applicable Participating Employer, or the Plan Administrator, Redwood Empire Municipal Insurance Fund, 2330 E. Bidwell Street, Suite 150, Folsom, CA 94530 , (707) 938-2388 x2.

SPECIAL ENROLLMENT PERIODS AND EFFECTIVE DATES

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

(1) Losing other coverage may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

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

(b) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(c) You certified in writing at the time you became eligible for coverage under this plan that you were declining coverage under this plan or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the group's next open enrollment period to do so.

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

(a) The Employee or Dependent has a loss of eligibility due to termination of employment or change in employment status, or reduction in the number of hours worked.

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

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

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

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

(f) The Employee or Dependent elects to terminate coverage under another employer sponsored group health plan during that plan's Open Enrollment period.

The Employee or Dependent must request enrollment in this Plan not later than 31 days after coverage described above ends. Coverage will begin the first of the month following the loss of coverage, but no later than the first day of the first calendar month following the date the completed enrollment form is received.

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

(2) **Acquiring a newly eligible Dependent may create a Special Enrollment right**. If:

(a) The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and;

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption, then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days after the date of the marriage, domestic partnership registration, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

(c) The Special Enrollment Period resulting from the acquisition of a new dependent also allows the member to make a plan change.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, or in the case of domestic partnership registration, coverage will be effective on the first of the month following the date you file the enrollment application.

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

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

(3) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right**. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

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

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

EFFECTIVE DATE

Effective Date of Employee Coverage.

Your effective date of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

(1) **Timely Enrollment**. If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for Employees, on your eligibility date; and (b) for family members, on the later of (i) the date the Employee's coverage begins, or (ii) the first day of the month after the family member becomes eligible. If you become eligible before the agreement takes effect, coverage begins on the effective date of the agreement, provided the enrollment application is on time and in order.

(2) **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the group's next Open Enrollment Period to enroll.

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

For late enrollees and disenrollees: You may enroll earlier than the group's next Open Enrollment Period if you meet any of the conditions listed under MID-YEAR ELECTION EVENTS or SPECIAL ENROLLMENT PERIODS.

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

TERMINATION OF COVERAGE

The Employer or Plan has the right to terminate any coverage of the Employee and/or Retiree and/or Dependents for making a fraudulent claim or an intentional misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage, so long as consistent with applicable law. If coverage is to be terminated or voided retroactively for fraud or intentional misrepresentation, the Plan will provide at least 30 days' advance written notice of such action and the impacted individual(s) will be given the opportunity to appeal as required by law. An advance notice and an opportunity to appeal is not required by law due to a Member's failure to timely pay a required contribution or the ineligibility of a Member (that was not an error of the Plan Administrator). The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

If a marriage or domestic partnership terminates, the Employee must give or send to the Participating Employer written notice of the termination within 60 days. Coverage for a former Spouses or Domestic Partners, and their dependent children, if any, ends according to the "Eligible Status" provisions outlined below. If the Plan suffers a loss because of the Employee failing to notify the Participating Employer of the termination of their marriage or domestic partnership, the Plan may seek recovery from the Employee for any actual loss resulting thereby. Failure to provide written notice to the Participating Employer will not delay or prevent termination of the marriage or domestic partnership. If the Employee notifies the Participating Employer in writing to cancel coverage for a former Spouse or Domestic Partner and the children of the Spouse or Domestic Partner, if any, immediately upon termination of the Employee's marriage or domestic partnership, such notice will be considered in compliance with the requirements of this provision.

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

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated. This includes elimination of an eligible class due to a Participating Employer's withdrawal from the REMIF plan.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes:

(a) death or termination of Active Employment of the covered Employee (or, if applicable, the covered Employee's reduction in hours). (See the section entitled Continuation Coverage Rights under COBRA.)

(b) Employee on disability leave of absence or other leave of absence, except for the continuation provisions set forth under the section entitled "Continuation During Periods of Employer Certified Disability or Leave of Absence" below.

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

(5) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage, so long as consistent with applicable law.

(6) If you voluntarily cancel coverage as a result of a qualifying event under a Section 125 Cafeteria Plan, coverage ends on the required contribution due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

Covered Employees who retire with a Participating Employer may be able to continue coverage under the Plan as a Retiree if they meet the eligibility requirements for retiree coverage as described in more detail in the Eligibility section above.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible to continue to participate in the Plan for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For approved leave of absence only: six calendar months from the last day worked.

For Employer-Certified Disability: twelve calendar months from the last day worked.

These continuances only apply if the Employer approves of the leave, and if the subscription charges continue to be paid (by the Employer and Member, as applicable). These time periods may be extended if required by law.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

To the extent a Plan Member has exhausted his or her twelve month period of coverage for an Employer-Certified Disability, the Member shall be eligible to continue coverage under the Plan so long as the Member is designated as an Active Employee by the Employer per the Employer's payroll records and is receiving workers' compensation benefits. Such continuation of coverage shall last until the Member's workers' compensation benefits have been exhausted or the Member's employment is terminated, whichever occurs earlier. Determination of an Employer-Certified Disability will be made in accordance with uniform policies established by the Plan Administrator (e.g. in accordance with long-term disability insurance requirements, etc.).

This continuation coverage described above is provided at the Employer's discretion. Any periods of coverage continuation required by COBRA will commence at the end of this discretionary continuation coverage. The discretionary continuation coverage described in this section may be terminated or otherwise modified at any time for any reason in the Employer's sole discretion. **Continuation During Family and Medical Leave.** This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor, as well as any state employment regulations which require additional periods of leave and are applicable to the Plan Administrator.

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within six months of the date of termination will be eligible for coverage the first day of the calendar month following the date the Employee returns to work. A terminated Employee who is rehired after six months of the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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

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

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

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

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

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service. 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 will not be enrolled at this time unless they qualify for another reason described elsewhere in this Plan. For reservists and their dependents applying for reinstatement of coverage following reemployment with the Employer, coverage will be effective as of the date of discharge from active duty.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Redwood Empire Municipal Insurance Fund, 2330 E. Bidwell Street, Suite 150, Folsom, CA 94530 , (707) 938-2388 x2.. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Coverage of Surviving Family Members. Enrolled family members may or may not be eligible to continue coverage under this plan after the Employee's or Retiree's death. Please check with the applicable Human Resources Department to determine whether or not the applicable Participating Employer offers this

continuation coverage as defined in the city/town policies, Participation Agreement and/or Memorandum of Understanding (MOU) and whether the required qualifications are met. Enrolled family members may also be entitled to COBRA continuation of coverage. Eligibility for COBRA is based on Federal law and is discussed under the section entitled Continuation Coverage Rights under COBRA in this booklet.

If offered, this continuation will end on the earliest of:

(1) The date the surviving Spouse or Domestic Partner remarries or enters into a new domestic partnership;

(2) The end of the period for which premiums are last paid to the Plan Administrator on the Covered Person's behalf;

(3) The date the Participating Employer cancels coverage for the class of Employees to which the Covered Person's deceased family member belonged;

(4) The date the policy terminates; or

(5) The premium due date coinciding with or following the date a child either (a) reaches age 26 or (b) no longer meets all of the conditions of coverage in the Eligibility, Funding, Effective Date and Termination Provisions.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the group provides to its Employees or their family members. The Covered Person may be responsible for all or part of the premium. A new dependent acquired during this continuation is not eligible to be enrolled as a family member.

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

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

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

(3) Coverage will end the last day of the calendar month in which the covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end the last day of the calendar month in which the Child ceases to meet the applicable eligibility requirements except as specified for "Disabled Children" below: (See the section entitled Continuation Coverage Rights under COBRA.)

(a) **Disabled Children:** If a child reaches the age limit shown in the "Eligible Status" provision of this section, the child will continue to qualify as a family member if he or she is (i) covered under this plan, (ii) chiefly dependent on the Employee, Spouse or Domestic Partner for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. The Employee must send proof of the child's physical or mental condition within 60-days of the date the Employee receives their COBRA notice. If we do not complete our determination of the child's continuing eligibility by the date the child reaches the plan's upper

age limit, the child will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the child is no longer chiefly dependent on the Employee, Spouse or Domestic Partner for support and maintenance or a physical or mental condition no longer exists. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

When Retiree Coverage Terminates. A covered Retiree's coverage will terminate as described in the Eligibility section above. Generally, a covered Retiree's coverage under this Plan will terminate upon attaining age 65 (except to the extent an individual turns 65 on the first of the month, in which case it will terminate the first of the month prior to the individual turning age 65). Upon reaching age 65 (or the first of the month prior, as applicable), such Retirees may be entitled to coverage under the REMIF Medicare Supplement Plan if the Participating Employer makes such coverage available to its Retirees and the Retirees otherwise satisfy the eligibility requirements set forth by the Participating Employer and REMIF in order to participate in that plan. Certain Retirees may be eligible for alternative coverage options; Participating Employers offering alternative coverage options to their Retirees will inform Retirees eligible for such alternative coverage of the terms of such coverage.

As noted in the Eligibility section above, a Dependent who is under age 65 is generally eligible to continue coverage under this Plan as long as the covered Retiree is under age 65, or, if age 65 or over, the Retiree enrolls in and remains covered by the REMIF Medicare Supplement Plan.

If you were a covered Dependent of a Retired Employee who died, and the applicable Participating Employer has adopted eligibility for surviving family members, you might be entitled to non-COBRA continuation coverage as described in the "Coverage of Surviving Family Members" section above. If applicable, such coverage for family members will be effective on the date of death.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may file an Appeal with the Plan Administrator by submitting a written request for appeal to REMIF at 2330 E. Bidwell Street, Suite 150, Folsom, CA 94530.. You should file your Appeal as soon as possible after you receive notice that your coverage will end. If your coverage is still in effect when you submit an Appeal, we will continue to provide coverage until your stated termination date. If your appeal is granted, coverage will be reinstated back to the first of the month following the date of termination provided that all subscription charges are paid. This appeal process does not apply if your coverage is cancelled for non-payment of subscription charges. If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf.

OPEN ENROLLMENT

At a time designated by the Participating Employer the annual open enrollment period will be held. During the annual open enrollment period, Covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the annual open enrollment period, eligible Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next July 1, unless there is a Mid-Year Election Event, as described in the "Mid-Year Election Events" section above.

Benefit choices for Late Enrollees made during the open enrollment period will become effective July 1.

Unless otherwise notified by a Participating Employer, a Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverages.

Covered Persons will receive detailed information regarding open enrollment from their Participating Employer, including information on required employee contribution amounts.

MEDICAL BENEFITS

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

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expenses incurred for services or supplies to be covered under this Plan.

(1) You must incur this expense while you are covered under this Plan. An expense is incurred on the date a Covered Person receives the service or supply for which the charge is made.

(2) The expense must be for a medical service or supply furnished to a Covered Person as a result of Illness, Sickness or Injury or pregnancy, unless a specific exception is made.

(3) The expense must be for a medical service or supply included in the section "MEDICAL CARE"

(4) The expense must not be for a medical service or supply listed in "MEDICAL CARE THAT IS NOT COVERED". If the service or supply is partially excluded for coverage under this Plan, then only that portion which is not excluded from coverage will be covered under this Plan.

(5) The expense must not exceed any of the maximum benefits or limitations of this Plan.

(6) Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the Illness, Injury, Sickness or degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your Illness, Sickness or Injury.

(7) For EPO Plans: All services and supplies must be ordered by the Network Provider or Non Network Provider provided in connection with Emergency Services or with an Authorized Referral.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the Single or Per Covered Person deductible shown in the Summary of Benefits **for your plan.**

Family Unit Limit. When the family maximum amount shown in the Summary of Benefits has been incurred by any combination of members of a Family Unit toward their family Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under "What the Plan Pays" on the Summary of Benefits **for your plan**. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Summary of Benefits for your plan is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Summary of Benefits for your plan for the rest of the Plan Year).

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Summary of Benefits for your plan for the rest of the Plan Year).

COVERED CHARGES

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

(1) **Hospital Care**. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or Outpatient Surgical Center or a Birthing Center and Covered Charges for room and board will be payable as shown in the Summary of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for a Private Room will be limited to the semi-private room rate. The private room rate will apply if the facility only has private rooms available.

Charges for an Intensive Care Unit stay are payable.

Benefit payments for Ambulatory Surgical Center or Outpatient Surgical Centers are limited as shown in the Summary of Benefits.

(2) **Coverage of Pregnancy.** The charges for the care and treatment of Pregnancy are covered the same as any Illness, including:

(a) All medical benefits for an enrolled member when provided for pregnancy or maternity care, including the following services:

(i) Prenatal and postnatal care.

(ii) Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other Medically Necessary maternity services performed outside of a Hospital.

(iii) Involuntary complications of pregnancy.

(b) Diagnosis of genetic disorders in case of high-risk pregnancy; and Inpatient Hospital care including labor and delivery Medical Hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an enrolled member. 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.

Certain services are covered under the "Preventive Care" benefit. Please see that provision for further details.

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

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Summary of Benefits.

(4) **Physician Care.** The professional services of a Physician or anesthetist for surgical or medical services.

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

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Maximum Allowable Amount that is allowed for the primary procedures; 50% of the Maximum Allowable Amount will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Amount for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowable Amount for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. Covered Services may include:

(a) Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.

(b) Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

(c) Services of a medical social service worker.

(d) Services of a health aide who is employed by (or who contracts with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as professional coordinator. These services are covered only if you are also receiving the services listed in (a) or (b) above.

(e) Medically necessary supplies provided by the home health agency.

In no event will benefits exceed 100 visits during a plan year. If the Plan applies covered charges toward the Plan Year Deductible and does not provide payment, those visits will be included in the 100 visits for that year.

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

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

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than one year and placed the person under a Hospice Care Plan. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Summary of Benefits and are available on a 24 hour basis for the management of a Covered Person's condition. Services may include:

(a) Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

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

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

(d) Social services and counseling services provided by a qualified social worker.

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

(f) Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

(g) Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member.

(h) Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

(i) Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Covered Person's or the family member's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your Spouse, children, step-children, parents, and siblings.

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

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Surgical methods of terminating a pregnancy also called elective **abortion**.

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

(c) The services of a Physician for **acupuncture treatment** to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electro acupuncture, cupping and moxibustion.

Benefit payments for acupuncture treatment is limited as shown in the Summary of Benefits.

(d) Local Medically Necessary professional land, water or air **ambulance** service. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. A charge for this item will be a Covered

Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Benefit payments for ambulance services are limited as shown in the Summary of Benefits.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger the patient's health and the patient's medical condition requires a more rapid transport to a Hospital than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if the patient is in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if the patient is taken to a Hospital that is not an acute care Hospital (such a Skilled Nursing Facility), or if the patient is taken to a Physician's office or to the patient's home.

Hospital to Hospital transport: if the Covered Person is being transported from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger the Covered Person's health and if the Hospital that first treats the Covered Person cannot give the Covered Person the medical services the Covered Person needs. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. For services to be covered, the Covered Person must be taken to the closest Hospital that can treat the Covered Person. Coverage is not provided for air ambulance transfers because the Covered Person, the Covered Person's family, or Covered Person's Physician prefers a specific Hospital or Physician.

Ambulance services are subject to medical necessity reviews.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes Medically Necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a Hospital. If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that an Emergency Medical Condition existed even if you are not transported to a Hospital.

(e) **Anesthetic**; **oxygen**; **blood and blood derivatives** intravenous injections and solutions. Administration of these items is included. 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.

(f) **Advanced Imaging procedures**, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre- authorization to determine medical necessity. See "Utilization Review Program" for details.

Benefit payments for advanced Imaging procedures are limited as shown in the Summary of Benefits.

(g) The following items and services when required for the Medically Necessary treatment of **pediatric asthma**:

(i) Nebulizers, including face masks and tubing. 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").

(ii) Inhaler spacers and peak flow meters. These items are covered under the prescription drug benefits and are subject to the copayment for brand name drugs (see the Prescription Drug Benefits).

(iii) 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.

(h) Services and supplies for **bariatric surgery** in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a designated CME or BDCSC facility.

The Covered Person must obtain pre-authorization for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a CME or BDCSC will not be covered.**

Bariatric Travel Charges. Certain travel charges incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC that is fifty (50) miles or more from the Covered Person's place of residence, are covered, provided the expenses are pre- authorized by the Utilization Review Administrator in advance. The fifty (50) mile radius around the BDCSC will be determined by the bariatric BDCSC coverage area. Our maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the Covered Person and/or one companion:

(i) Transportation for the Covered Person and/or one companion to and from the BDCSC.

(ii) Lodging, limited to one room, double occupancy.

(iii) Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric BDCSC. Details regarding reimbursement can be obtained by calling the customer service number on the I.D. card.

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

(i) Services and supplies provided in connection with the screening for, diagnosis of, and treatment for **breast cancer** whether due to illness or injury, including:

(i) Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

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

(iii) Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

(iv) Reconstructive surgery of both breasts performed to restore and achieve symmetry following a Medically Necessary mastectomy.

(v) Breast prostheses following a mastectomy (see "Prosthetic Devices").

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

(j) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a medical care facility.

(k) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

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

(m) Routine patient care charges for **Clinical Trials.** The services must be those that are listed as covered by this plan for Covered Persons 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. Coverage is limited to the following clinical trials:

(i) Federally funded trials approved or funded by one or more of the following:

- The National Institutes of Health,
- The Centers for Disease Control and Prevention,
- The Agency for Health Care Research and Quality,
- The Centers for Medicare and Medicaid Services,
- A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,

- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

- 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.

(ii) Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

(iii) 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 (see the DEFINITIONS section).

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:

(i) The investigational item, device, or service itself.

(ii) 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.

(iii) Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(iv) 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. Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in CLAIMS AND APPEALS PROCEDURES.

(n) Initial **contact lenses** or glasses required following cataract surgery.

(o) Contraceptives and products for contraceptive management including, but not limited to:

(i) Injectable drugs and implants for birth control, administered in a physician's office, if Medically Necessary.

(ii) Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a physician if Medically Necessary.

(iii) 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.

Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

(p) Dental Care.

(i) 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 Plan 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 (ii), below.

(ii) 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.

(iii) Dental Injury. Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such 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 natural teeth due to chewing or biting is not accidental injury.

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

(v) Orthognathic surgery. Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

Important: If you decide to receive dental services that are not covered under this Plan, a Network Provider who is a dentist will charge you his or her billed rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call us at the customer service telephone number listed on your ID card.

(q) Services and supplies provided for a **diabetes education program** which:

(i) Is designed to teach an Covered Person who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

(ii) Includes self-management training, education, and medical nutrition therapy to enable the Covered Person to properly use the equipment, supplies, and medications necessary to manage the disease; and

(iii) Is supervised by a Physician.

Diabetes education services are covered under plan benefits of office visits to physicians.

(r) Services and supplies provided for **diabetes equipment and supplies**, including:

(i) Some blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

(ii) Insulin pumps.

(iii) Pen delivery systems for insulin administration (non-disposable).

(iv) Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

(v) Podiatric devices, such as therapeutic shoes and shoe inserts. To treat diabetes- related complications.

(vi) Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please review that provision for details.

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

The following items are covered under your prescription drug benefits:

- Insulin, glucagon, and other prescription drugs for the treatment of diabetes.
- Insulin syringes, disposable pen delivery systems for insulin administration.
- Testing strips, lancets, and alcohol swabs.

- Certain blood glucose monitors

These items must be obtained either from a retail pharmacy or through the home delivery program. See Your Prescription Drug Benefits for details.

(s) **Diagnostic Services.** Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures" provision of this section.

(t) **Durable Medical Equipment** for rental or purchase, if deemed Medically Necessary. Rental or purchase of **dialysis equipment, dialysis supplies, and other medical equipment** if deemed Medically Necessary. Rental or purchase of other medical equipment and supplies which are:

(i) Of no further use when medical needs end;

(ii) For the exclusive use of the patient;

(iii) Not primarily for comfort or hygiene;

(iv) Not for environmental control or for exercise; and

(v) Manufactured specifically for medical use.

If purchased, the cost of the item shall not exceed the fair market value of the equipment at the time of purchase, and will only be covered if agreed to in advance by the Plan Administrator. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending Physician.

Specific durable medical equipment is subject to pre-authorization to determine medical necessity.

(u) Charges for orthopedic footwear used as an integral part of a brace; **foot orthotics** that are custom molded to the patient.

(v) **Genetic testing** for the purpose of determining the need for fetal therapy or to determine a Medically Necessary intervention for the mother.

(w) 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.

(i) 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.

(ii) Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

(iii) Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No benefits will be provided for the following:

(i) Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

(ii) Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically Necessary surgically implanted hearing devices may be covered under this Plan's benefits for prosthetic devices.

(x) The following services and supplies when provided by a **home infusion therapy** provider in the home for the intravenous administration of the patient's 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:

(i) Medication, (specialty drugs must be obtained through the specialty drug program (See "Specialty Drugs" provision of this section), ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however medication which is delivered but not administered is not covered;

(ii) Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

(iii) 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;

(iv) Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

(v) Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy services are subject to pre-authorization to determine medical necessity. Benefit payments for home infusion therapy shown in the Summary of Benefits.

(y) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**. The Plan will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

(z) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(aa) Treatment of **Mental Disorders and Substance Abuse**. Covered Services shown below for the Medically Necessary treatment of mental or nervous disorders or substance abuse, or to prevent the deterioration of chronic conditions.

(i) Inpatient Hospital services and services from a residential treatment center as stated in the "Hospital" provision of this section, for inpatient services and supplies.

(ii) Partial hospitalization, including intensive outpatient programs and visits to a day treatment center. Partial hospitalization is covered as stated in

the “Hospital” provision of this section, for outpatient services and supplies.

(iii) Physician visits during a covered inpatient stay.

(iv) Physician visits for outpatient psychotherapy or psychological testing for the treatment of mental or nervous disorders or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

(v) Behavioral health treatment for pervasive developmental disorder or autism. See the section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism for a description of the services that are covered. Note: For services received prior to February 1, 2023, you must obtain pre-authorization for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan. No benefits are payable for these services received prior to February 1, 2023 if pre-authorization is not obtained. Effective February 1, 2023, pre-authorization is not required for behavioral health treatment services for the treatment of pervasive developmental disorder or autism.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

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

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Emergency repair due to Injury to sound natural teeth.

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

Excision of benign bony growths of the jaw and hard palate. External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

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

(cc) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Occupational therapy programs are designed to maximize or improve a patient’s extremity function, perceptual motor skills and ability to function in daily living activities. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Occupational therapy is limited as shown in the Summary of Benefits.

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.

Up to 24 visits in a year for all covered physical therapy, physical medicine and occupational therapy services are payable, if Medically Necessary. If additional visits are needed after receiving 24 visits in a year, pre-authorization must be obtained prior to receiving the services.

If we determine that an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, we will authorize a specific number of additional visits. Such additional visits are not payable if pre-authorization is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

If we apply covered charges toward the Plan Year Deductible and do not provide payment, that visit will be included in the visit maximum (24 visits) for that year.

(dd) **Online Care Services/Telemedicine**. Covered Charges for medical consultations using the internet via webcam, camera phone, chat or voice. The Plan has contracted with a telemedicine vendor, LiveHealth Online, to provide telemedicine services to Covered Persons. In most cases, using LiveHealth Online for telemedicine services will result in the lowest cost sharing responsibility for you, and LiveHealth Online may be the most convenient to access. However, the Plan generally covers telemedicine from other health care providers as well, if the consultation is deemed Medically Necessary and otherwise satisfies the terms and conditions for coverage under this Plan. Covered Services include, but are not limited to, virtual "office" visits with physicians and consultations for members while admitted to the hospital or as patients in the Emergency Room. Non-covered services include, but are not limited to:

- Reporting normal lab or other test results, when done by administrative staff or a non-treating healthcare practitioner outside of a telehealth consultation.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Patient telephone calls or emails to physicians or other healthcare practitioners or their administrative staff solely for the purpose of requesting a referral to another physician or healthcare practitioner.
- Benefit Pre-authorization.
- Consultations between physicians.

Note: You will be financially responsible for the costs associated with non-covered services. An itemized receipt for services will be required for claim reimbursement.

(ee) Services and supplies provided in connection with a non-investigative **organ or tissue transplant**, if the Covered Person is:

(i) The recipient; or

(ii) The donor.

Benefits for an organ donor are as follows:

(i) When both the person donating the organ and the person getting the organ are Covered Persons, each will get benefits under their plans.

(ii) When the person getting the organ is a Covered Person, but the person donating the organ is not, benefits under this plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

(iii) If the Covered Person is donating the organ to someone who is **not** a Covered Person, benefits are not available under this plan.

The Maximum Allowable Amount for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary medical services only. The Maximum Allowable 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. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. Payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants is payable as shown in the Summary of Benefits.

Covered Services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the Summary of Benefits. The Maximum Allowable Amount does not include charges for services received without first obtaining pre-authorization or which are provided at a facility other than an approved transplant center approved by us. See Cost Management Services for details.

To maximize benefits, the patient should call the Utilization Review Administrator as soon as the patient thinks a transplant may be needed to talk about the benefit options. This must be done before an evaluation or work-up for a transplant. The transplant coordinator will help maximize the benefits by giving the patient coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) rules, or which exclusions (if any) apply. Call the Pre-authorization phone number on the back of the identification card to speak with the Utilization Review Administrator.

You or your physician must call the Utilization Review Administrator for Pre-authorization review prior to the transplant. Pre-authorization is required before benefits are provided for a transplant, whether it is performed in an inpatient or outpatient setting. The patient's Physician must certify, and the Utilization Review Administrator must agree, that the transplant is Medically Necessary. Physician should send a written request for Pre- authorization to the Utilization Review

Administrator as soon as possible to start this process. Not getting Pre-authorization may result in a denial of benefits.

Please note that the Physician may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or harvest and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

Pre-authorization must obtained for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC). **Charges for services provided for or in connection with a specified**

transplant performed at a facility other than a CME or BCDSC will not be considered covered. Call the toll-free telephone number for Pre-authorization on the identification card if the Physician recommends a specified transplant for the patient's medical care. A case manager will assist in facilitating access to a CME or BDCSC. See Cost Management Services for details.

Transplant Travel Charges

Certain travel expenses 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 CME or BDCSC that is 75 miles or more from the recipient's or donor's place of residence are covered. The maximum payment will not exceed **the amount shown in the Summary of Benefits** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

(i) Ground transportation to and from the CME or BDCSC when the designated CME or BDCSC is 75 miles or more from the recipient's or donor's place of residence.

(ii) Coach airfare to and from the CME or BDCSC when the designated CME or BDCSC is 300 miles or more from the recipient's or donor's residence.

(iii) Lodging, limited to one room, double occupancy.

(iv) Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

*Note: When the Covered Person recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

For certain plans the Plan Year Deductible will not apply and no Copayments will be required for transplant travel charges pre-authorized in advance by the Utilization Review Administrator. Benefits will be provided for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code. See your Summary of Benefits for details.

Charges incurred for the following are not covered: travel expenses for 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 the customer service number on the identification card. A claim form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

(ff) **Orthognathic surgery** for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

(gg) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(hh) 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 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.

Prior to February 1, 2023, you must obtain pre-authorization for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this Plan (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services received prior to February 1, 2023 if pre-authorization is not obtained. Effective February 1, 2023, pre-authorization is not required for behavioral health treatment services for the treatment of 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 Behavioral 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:

(i) The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,

(ii) 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

(iii) 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:

- Describes the patient's behavioral health impairments to be treated,
- 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,
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- 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 upon request.

(ii) **Physical therapy and Physical medicine** must be administered in strict accordance with the referring Physician's orders regarding type of therapy, frequency and duration. The condition treated must also be established as one which receives substantial benefit from short-term therapy. Care must be provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

Physical therapy is limited as shown in the Summary of Benefits.

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.

Up to 24 visits in a year for all covered physical therapy, physical medicine and occupational therapy services are payable, if Medically Necessary. If additional visits are needed after receiving 24 visits in a year, pre-authorization must be obtained prior to receiving the services.

If we determine that an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, we will authorize a specific number of additional visits. Such additional visits are not payable if pre-authorization is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

If we apply covered charges toward the Plan Year Deductible and do not provide payment, that visit will be included in the visit maximum (24 visits) for that year.

(jj) Special food products and formulas that are part of a diet prescribed by a Physician for the treatment of **phenylketonuria (PKU)**.

(kk) **Prescription Drugs Obtained From or Administered By a Medical Provider.** Your plan includes benefits for prescription drugs when they are administered to you as part of a physician visit, services from a home health agency, or at an outpatient Hospital. This includes drugs for infusion therapy, chemotherapy, specialty pharmacy drugs, and blood products. This section describes your benefits when your physician orders the medication and administers it to you. Benefits are also available for prescription drugs that you receive under your prescription drug benefits, if included.

Non-duplication of benefits applies to pharmacy drugs under this plan. When benefits are provided for pharmacy drugs under the plan's medical benefits, they will not be provided under your prescription drug benefits, if included. Conversely, if benefits are provided for pharmacy drugs under your prescription drug benefits, if included, they will not be provided under the plan's medical benefits.

Pre-Authorization. Certain specialty pharmacy drugs require written pre-authorization of benefits in order for you to receive them. Pre-authorization criteria will be based on medical policy and the pharmacy and therapeutics process. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through pre-authorization that the drug originally prescribed is Medically Necessary and is cost effective, you will be provided the drug originally requested. If, when you first become a member, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a drug other than the one you are currently taking.

In order for you to get a specialty pharmacy drug that requires pre-authorization, your physician must make a request to us for you to get it. The request may be made by either telephone or facsimile to us. At the time the request is initiated,

specific clinical information will be requested from your physician based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the physician's statement in the request or clinical rationale for the specialty pharmacy drug.

If the request is not for urgently needed drugs, after we get the request from your physician:

- Based on your medical condition, as Medically Necessary, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your physician what we have decided in writing - by fax to your doctor, and by mail, to you.

- If more information is needed to make a decision, we will tell your physician in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem by telephone, and in writing by facsimile, to your physician, and in writing to you by mail.

- As soon as we can, based on your medical condition, as Medically Necessary, within 5-business days after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to your physician and by mail to you.

If you have any questions regarding whether a specialty pharmacy drug requires pre- authorization, please call the number listed on your ID Card.

If we deny a request for pre-authorization of a specialty pharmacy drug, you or your prescribing physician may appeal our decision by calling the number listed on your ID card. If you are not satisfied with the resolution based on your inquiry, you may file an Appeal with us by following the procedures described in the section entitled HOW TO SUBMIT A CLAIM.

(II) Routine **Preventive Care Services.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Summary of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. The plan year deductible will not apply to these services or supplies. No copayment will apply to these services or supplies. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings as ordered by an examining physician for: breast cancer (including BRCA testing if appropriate in conjunction with genetic counseling and evaluation), cervical cancer, human papillomavirus (HPV), human immunodeficiency virus (HIV), prostate cancer, colorectal cancer, other medically accepted cancer screening tests, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, blood lead levels, iron deficiency anemia in pregnant women, and obesity.

- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

    - All FDA-approved contraceptive methods for women, including over the counter items, if prescribed by a physician. In order to be covered as preventive care, contraceptive prescription drugs must be either generic or single source brand name drug. Also covered are sterilization procedures and counseling.

    - Breastfeeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

    - Gestational diabetes screening.

- Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

- Preventive services for certain high-risk populations as determined by a physician, based on clinical expertise.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and

- www.cdc.gov/vaccines/recs/acip/

In accordance with Section 4203 of the CARES Act, the Plan will cover vaccines and other qualifying preventive services for COVID-19 on an expedited basis

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury, Illness or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury, Illness or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for children includes services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

    - Diphtheria,

    - Pertussis,

- Tetanus,
- Polio,
- Measles,
- Mumps,
- Rubella,
- Hemophilus influenza b (Hib),
- Hepatitis B,
- Varicella.

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(mm) Coverage of **prosthetic devices**:

(i) Breast prostheses following a mastectomy.

(ii) Prosthetic devices to restore a method of speaking when required as a result of a covered Medically Necessary laryngectomy.

(iii) The Plan will pay for other Medically Necessary prosthetic devices, including:

- Surgical implants;
- Artificial limbs or eyes;
- The first pair of contact lenses or eye glasses 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; and
- Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

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

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

This does not apply to orthognathic surgery. Please see the "Dental Care" provision below for a description of this service.

(oo) Charges associated with **Retail Health Clinics** provided by medical professionals who provide basic medical services in a retail health clinics including, but not limited to:

(i) Exams for minor illnesses and injuries

(ii) Preventive services and vaccinations

(iii) Health condition monitoring and testing

(pp) Care and treatment for **sleep disorders** when deemed Medically Necessary.

(qq) **Speech therapy** by a licensed therapist.

(rr) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license. Spinal Manipulation services are limited as shown in the Summary of Benefits.

(ss) **Sterilization** procedures.

(tt) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(uu) Services and supplies provided in connection with **transgender services** when the patient has been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to Plan benefits that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Plan's prescription drug benefits (if such benefits are included).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to pre-authorization in order for coverage to be provided.

Transgender Travel Expense. Certain travel charges incurred in connection with an approved transgender surgery, when the Hospital at which the surgery is performed is 75 miles or more from the Covered Person's place of residence,

provided the charges are pre- authorized in advance by the Utilization Review Administrator. The maximum payment will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel charges incurred by the patient and one companion:

(i) Ground transportation to and from the Hospital when it is 75 miles or more from the patient's place of residence.

(ii) Coach airfare to and from the Hospital when it is 300 miles or more from the patient's residence.

(iii) Lodging, limited to one room, double occupancy.

(iv) Other reasonable charges. Tobacco, alcohol, drug, and meal charges are excluded.

For certain plans, the Plan Year Deductible will not apply and no copayments will be required for transgender travel charges pre-authorized in advance by the Utilization Review Administrator. Benefits will be provided for lodging, transportation, and other reasonable charges up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non- surgical transgender services. Please see the Summary of Benefits for details.

Details regarding reimbursement can be obtained by calling the customer service number on the identification card. A claim form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

(vv) Services and supplies received from an **Urgent Care** center to prevent serious deterioration of the patient's health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Services for Urgent Care are typically provided by an Urgent Care center or other facility such as a Physician's office.

(ww) Coverage of **Well Newborn Nursery/Physician Care**.

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

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Mid-Year Election Events or Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for nursery care for the newborn child while Hospital confined as a result of the child's birth, if the child's natural mother is a Covered Person.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

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

Charges for Routine Physician Care. The benefit is limited to the charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth, if the child's natural mother is a Covered Person.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided the child is added to the Plan and coverage is in effect.

(xx) Charges associated with the initial purchase of a **wig after chemotherapy** are payable as shown in the Summary of Benefits.

(yy) Diagnostic **x-rays**.

Special Note Regarding COVID-19: As required by applicable law, the Plan will cover certain items and services related to medically necessary diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 without imposing any cost sharing or pre-authorization requirements during the public health emergency.

CELLULAR OR GENE THERAPY COVERAGE

The Plan covers certain Medically Necessary cellular or gene therapy pharmaceuticals as described below. Effective July 1, 2024, the following pharmaceuticals are covered by the Plan:

- Luxturna, for Leber Congenital Amaurosis (LCA) hereditary blindness;
- Zolgensma, for Spinal Muscular Atrophy (SMA) Type 1 and Type 2;
- Spinraza, for Spinal Muscular Atrophy (SMA) Type 1 and Type 2;
- Skysona, for Cerebral adrenoleukodystrophy (CALD); and
- Zynteglo, for Transfusion Dependent Beta Thalassemia (TDT).

The Plan Administrator may modify the cellular and gene therapies covered by the Plan at any time. The Plan does not cover any cellular or gene therapies which are not listed above.

COST MANAGEMENT SERVICES

Cost Management Services include:

- Utilization Review

- Second and Third Opinion Program
- Pre-Admission Testing Services
- Case Management

Cost Management Services Phone Number

Please call the numbers listed on your ID Card or call HealthComp for additional information on Cost Management Services.

The provider, patient or family member must call the number for Pre-Authorization Review to receive certification of certain Cost Management Services. This call must be made at least 5 days in advance of services being rendered or within 72 hours after receiving Emergency Services.

Failure to follow cost management procedures may result in the reduction of the Plan's reimbursement level, and any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the deductible or the maximum out-of-pocket payment.

UTILIZATION REVIEW

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

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

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

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

Certain services require pre-authorization of benefits in order for benefits to be provided. Network Providers will initiate the review on your behalf. A Non-Network Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your physician to request pre-authorization. You may also call us directly. Pre-authorization criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments that are more cost effective.

It is your responsibility to determine whether a particular service requires pre-authorization. Please read the following information to assist you in this determination and please feel free to call the toll-free number for pre-authorization printed on your identification card if you have any questions about making this determination.

It is also your responsibility to see that your physician starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits may be reduced.

Pre-authorization does not confirm or verify eligibility for coverage, nor is it a guarantee of payment.

The program consists of:

(1) Pre-authorization of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided (except as described in the Surprise Medical Bills Notice):

Autism Treatment (effective until February 1, 2023)
Applied Behavioral Analysis Therapy (effective until February 1, 2023)
Air Ambulance for Non-Emergent Transport
All Bariatric Procedures
Certain Prosthetics Diagnostics, including:

- **AmniSure® ROM Test**
- **Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening**
- **Genetic testing for cancer susceptibility**
- **Genetic testing for Inherited Peripheral Neuropathies**
- **Genetic testing for PTEN Hamartoma Tumor Syndrome**
- **High technology radiology services such as MRI, MRA, MEG, PET, CAT, CTA, MRS, CT/PT, SPECT, ECHO cardiology, nuclear technology services**
- **Myocardial sympathetic innervations imaging with or without SPECT**
- **Thyroid Fine Needle Aspirate Molecular Markers Durable Medical Equipment**

Facility Based Substance Abuse/Mental Disorder treatments
Foot Orthotics
Home Health Care
Infusion Therapy
Inpatient Hospitalizations, including:

- **Elective Admissions**
- **OB Related Medical Stay (OB complications, Excludes childbirth)**
- **Newborn Stays beyond Mother (NICU)**
- **Inpatient Skilled Nursing Facility**
- **Rehabilitation Facility Admissions**

Organ, Bone Marrow, and Stem Cell Transplants
Outpatient surgical procedures and treatments
Rehabilitation services beyond stated Plan limits
Sex Change/Transgender Surgical Procedures

If you proceed with any services that have been determined to be not Medically Necessary and appropriate at any stage of the Pre-authorization process, benefits will not be provided for those services.

(2) Retrospective review for Medical Necessity is performed to review services that have already been provided. This applies in cases when pre-authorization or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be provided for those services. Remaining benefits may be subject to previously noted reductions and limitations that apply when the required reviews are not obtained.

(3) Concurrent review determines whether services are Medically Necessary and appropriate when we are notified while services is ongoing, for example an emergency admission to the Hospital.

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

The purpose of the program is to determine what charges may be Medically Necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

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

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

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

HOW TO OBTAIN UTILIZATION REVIEW

Remember, it is always your responsibility to confirm that the pre-authorization has been performed. If the pre- authorization is not performed your benefits may be reduced as shown in the Summary of Benefits.

Pre-authorization

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, authorize the care. Pre-authorization does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Physicians who are Network Providers will initiate the review on your behalf. A Non Network provider may initiate the review, or you must call the Pre-Authorization Review telephone number on the Covered Person's ID card **at least 5 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If you do not receive the reviewed service within 60 days of the Pre-authorization, or if the nature of the service changes, a new Pre-Authorization review must be obtained.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 72 hours** of the first business day after the admission.

The utilization review administrator will pre-authorize the number of days of Medical Care Facility confinement as determined by medical necessity. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive Pre-authorization as explained in this section, the benefit payment may be reduced or denied.

Concurrent Review and Discharge Planning

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

If we determine that the service is not Medically Necessary and appropriate, your physician will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your physician within two business days following our decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon. If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-authorized, the attending Physician must request the additional services or days.

If Pre-authorization was not obtained, you, your physician or the provider of the service must contact us for Concurrent Review. For an emergency admission or procedure, we must be notified within one working day of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.

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

Retrospective Reviews

- If a pre-authorization or a concurrent review was not performed, a retrospective review will be done to review services that have already been provided to determine if they are Medically Necessary.

- Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review. It is also performed when pre-authorization or concurrent review has been done, but services continue longer than originally certified.

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

- Such services which have been retroactively determined to not be Medically Necessary and appropriate will be retrospectively denied authorization.

THE MEDICAL NECESSITY REVIEW PROCESS

We work with you and your health care providers to cover Medically Necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, we are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our review process.

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

When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-authorization request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

(2) A decision on the medical necessity of a concurrent review request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

(3) A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your physician.

(4) If we do not have the information we need, we will make every attempt to obtain that information from you or your physician. If we are unsuccessful, and a delay is anticipated, we will notify you and your physician of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.

(5) All pre-authorization, concurrent review, and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Such criteria and policies are incorporated into the Plan by reference herein and constitute binding Plan terms and conditions. Requests satisfying these criteria are certified as Medically Necessary. Review Coordinators are able to approve most requests.

(6) For pre-authorization and concurrent review requests, written confirmation including the specific service determined to be Medically Necessary will be sent to you and your provider no later than two business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-authorization and concurrent reviews.

(7) If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to authorize the service, the

requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to authorize the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

(8) Only the Peer Clinical Reviewer may determine that the proposed services are not Medically Necessary and appropriate. Your physician will be notified by telephone within 24 hours of a decision not to authorize and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

- an explanation of the reason for the decision,
- reference of the criteria used in the decision to modify or not authorize the request,
- the name and phone number of the Peer Clinical Reviewer making the decision to modify or not authorize the request,
- how to request reconsideration if you or your provider disagree with the decision.

(9) Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

(10) You or your physician may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

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

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

(11) Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

(12) You or your physician may request copies of specific criteria and/or medical policies by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this plan ends;
- The agreement with the group terminates;

- You reach a benefit maximum that applies to the services in question;
- Your benefits under the plan change so that the services in question are no longer covered or are covered in a different way.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

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

(1) performed on an outpatient basis before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

CASE MANAGEMENT

The case management program helps coordinate services for Covered Persons with health care needs due to serious, complex, and/or chronic health conditions. If a Covered Person qualifies for and agrees to participate in a case management program, a case manager will work closely with the Covered Person, the Covered Person's family, the attending Physician, and other health care providers to ensure that the

Covered Person receives appropriate care in the most effective setting possible, whether at home, as an outpatient, or inpatient in a Hospital or specialized facility. In addition, the case manager may assist in coordinating care with existing community-based programs and services the Covered Person may need. This may include giving information about external agencies and community-based programs and services.

The case manager assists in determining appropriate treatment options which will best meet the Covered Person's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support. Case managers are credentialed health care professionals, trained in the appropriate clinical specialty area that applies to the Covered Person's condition.

The case management program is confidential and voluntary and is made available to you at no extra cost to you, if you qualify for the program. The case management program is separate from any Covered Services you may receive under the Plan. Eligible participants for the case management program will be identified through the utilization review procedures. In addition, you may request a case manager for a particular condition you may have, but the Plan is not obligated to provide a case manager to you. The Plan Administrator has the right in its sole and absolute discretion to determine who may participate in the case management program. A case manager is not assigned to every Covered Person. The case management program is only appropriate for Covered Persons with certain conditions that serious, complex, and/or chronic.

In certain cases, the case management program may authorize alternative benefits as described in the "Alternative Benefits" section below.

ALTERNATIVE BENEFITS

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

Through the case management program, the Plan has the right to recommend and authorize an alternative treatment plan in order for the Covered Person to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolong periods of intensive medical care. It is the Plan's right to utilize the case management program to determine if an offer of alternative benefits will be made. The Plan Administrator may exercise this right in its sole and absolute discretion.

Covered Persons eligible for potential alternative benefits will be identified through the Plan's utilization review procedures. A Covered Person may also make a request for alternative benefits to the Plan Administrator; however, the Plan has no obligation to accept such a request.

To determine if alternative benefits will be covered by the Plan, a case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

If approved by the attending Physician and the patient, the case manager will coordinate and implement the alternative benefits program. Once a plan of care is developed, the Plan Administrator will direct the Plan to cover Medically Necessary charges as stated in the treatment plan, even if these charges normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for charges incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

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

Any decision regarding treatment belongs to you and your physician. The plan will, in no way, compromise your freedom to make such decisions. The terms of this document control Plan coverage, not treatment decisions. However, note that if you choose a treatment that is not covered by the Plan, the Plan will not pay for any costs associated with such treatment.

DEFINED TERMS

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

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

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

An **Appeal** is a formal written request for review following an adverse benefit decision.

Applied Behavioral 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.

Authorized Referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

- There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of your residence or within the county in which your residence is located, whichever is less; and
- You are referred in writing to the non-participating provider by the physician who is a participating provider; and
- Exception For Chiropractic Care only: There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 20-mile radius of your residence or within the county in which your residence is located, whichever is less; and
- We have authorized the referral before services are rendered.

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

Such Authorized Referrals are not available to bariatric surgical services. These services are only covered when performed at a bariatric CME.

If authorized services are received from a Non-Network provider you may be billed by the provider for the difference between the billed charges and the plan's Maximum Allowable Amount. In many situations, this difference could be significant.

BDCSC means Blue Distinction Centers for Specialty Care.

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

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

Brand Name Drug means a drug marketed under a proprietary, trademark-protected name.

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

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

Coinsurance is the Covered Person's share of the cost for Covered Services which is a percentage of the Allowable Amount. Coinsurance is paid after the deductible has been met. Coinsurance is listed in the Summary of Benefits.

Copayment means a fixed amount of money that is paid each time a particular service is used. There may be copayments on some services and not on other services Copayments are listed in the Summary of Benefits.

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

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Custodial Care is care provided primarily to meet personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Domestic Partner means an individual who meets the Plan's eligibility requirements for Domestic Partners outlined in the eligibility section.

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

Eligibility Date for a new hire or a newly eligible employee is the effective date assigned based on the date of hire and the Participating Employer's waiting period guidelines. The Eligibility Date for those enrolling because of a permitted Mid-Year Election Event may vary based on the specific event.

Embedded Out-of-Pocket means once an individual reaches the single coverage out-of-pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Plan Year unless

stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Plan Year unless stated otherwise.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, 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 a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act. In that section, such clauses refer to (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in the serious jeopardy, (ii) serious impairment to body functions, or (iii) serious dysfunction of any body organ or part. An Emergency Medical Condition includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, a psychiatric emergency medical condition, or convulsions or other such acute medical conditions.

Final determination as to whether services were rendered in connection with an Emergency Medical Condition will rest solely with the Plan.

Emergency Services With respect to an Emergency Medical Condition, (i) an appropriate medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, such further medical examination and treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). In addition, Emergency Services include certain items and services (known as "post-stabilization services") (i) for which benefits are provided or covered under the Plan, and (ii) that are furnished by an out-of-network Provider or emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services described in the preceding sentence are furnished; provided, however, that such items and services are **not** included as Emergency Services if all of the conditions in 45 CFR 149.410(b) are met.

For purposes of this definition, "to stabilize" has the meaning given in section 1867(e)(3) of the Social Security Act; "emergency department of a hospital" includes a hospital outpatient department that provides emergency services; and "independent freestanding emergency department" means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable state law and provides Emergency Services.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship; or a person defined as eligible under the City/Town policies, Participation Agreement and/or Memorandum of Understanding (MOU).

Employer or Participating Employer is a city, town, or other local government entity that has chosen to participate in the Redwood Empire Municipal Insurance Fund. A list of Participating Employers can be found in Appendix A of this Plan.

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

Experimental procedures (Experimental) are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. The Utilization Manager has discretion to make this determination. However, if a Member has a seriously debilitating condition and the Utilization Manager determines that requested treatment is not a Covered Service because it is Experimental, the Member may request an Independent Medical Review.

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

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan. The formulary drug list and prescription drug coverage, restrictions, and limitations are determined by the Pharmacy Benefits Manager and can change during the Plan Year.

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

Genetic Information means information about the genetic tests of an individual or his/her family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes as defined by the Genetic Information Nondiscrimination Act of 2008 (GINA).

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the home, and is recognized as a home health provider under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care offered under the plan is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

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

Hospice Agency 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 section 1726 and 1747.1.

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

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

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

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

For limited purpose of inpatient care, the definition of Hospital also includes: (1) psychiatric health facilities (only for the acute phase of a mental or nervous disorder or substance abuse), and (2) residential treatment centers.

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

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

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, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

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

Investigational procedures (Investigational) are those:

(1) That have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or

(2) That do not have final approval from the appropriate governmental regulatory body; or

(3) That are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or

(4) That do not improve the health outcome of the patient treated; or

(5) That are not beneficial as any established alternative; or

(6) Whose results outside the Investigational setting cannot be demonstrated or duplicated; or

(7) That are not generally approved or used by Physicians in the medical community.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or the time period permitted for a Mid-Year Election Event (if applicable).

Maximum Allowable Amount is a charge which is either the Network Provider's reduced fee or the Recognized Charge for a service or supply. Except as otherwise required by law, the Maximum Allowable Amount is the total reimbursement payable under the plan for Covered Services received from Network Providers, Non-Network Providers, or other health care providers. If services are received from a Non-Network Provider, you may be billed by the provider for the difference between the billed charges and the plan's Maximum Allowable Amount. In many situations, this difference could be significant. However, see the Surprise Medical Billing Notice for a description of circumstances in which you will not be balance billed.

If a service or supply is more expensive than an equivalent service or supply that is medically appropriate and is likely to produce the equivalent therapeutic or diagnostic result for the Covered Person, the Maximum Allowable Amount will be based on the less expensive service or supply, even if the Covered Person chooses the more expensive service or supply, unless otherwise required under a contract with a Network Provider or by law or unless the Plan Administrator determines an exception is warranted in its sole and absolute discretion.

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

Medically Necessary procedures, supplies, equipment or services are those we determined to be:

(1) Appropriate and necessary for the diagnosis or treatment of the medical condition;

(2) Provided for the diagnosis or direct care and treatment of the medical condition;

(3) Within standards of good medical practice within the organized medical community;

(4) Not primarily for our convenience, or for the convenience of the physician or another provider; and

(5) Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

(6) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

(a) there must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and

(b) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

(c) for Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the patient's condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary, and whether an exception to the Medical Necessity requirement is available.

If a service or supply is more expensive than an equivalent service or supply that is medically appropriate and is likely to produce the equivalent therapeutic or diagnostic result for the patient, the more expensive service or supply shall not be Medically Necessary, unless the Plan Administrator deems an exception is warranted in its sole and absolute discretion.

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

Member is the covered employee or retiree, or the covered family member.

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

Network Provider is one of the following providers or other licensed health care professionals who have a Network Provider Agreement in effect with the Plan's contracted network 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 agency or unit
- A licensed ambulance company
- A licensed qualified autism service provider

Network Providers agree to accept the Maximum Allowable Amount as payment for Covered Services. You may review the directory of Network Providers or search for a Network Provider using the "Provider Finder" function on our website.

Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Non-Network Provider is one of the following providers or other licensed health care professionals who DOES NOT have a Network Provider Agreement in effect with the Plan's contracted network 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 agency or unit
- A licensed ambulance company
- A licensed qualified autism service provider

Non-Network Providers are not required to accept the Maximum Allowable Amount as payment for Covered Services. You may review the directory of Network Providers or search for a Network Provider using the "Provider Finder" function on our website.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Pharmacy is a pharmacy which does not have a contract in effect with the pharmacy benefits manager at the time services are rendered.

No Surprises Act the "No Surprises Act," which was enacted in Title I of Division BB of the Consolidated Appropriations Act of 2021, including the regulations and binding guidance issued thereunder, which generally governs patient cost sharing, balance billing, and payments to providers for Emergency Services rendered in Non-Network facilities, services rendered by Non-Network Providers in Network facilities, and services rendered by air ambulance providers. (For more details, see the Surprise Medical Bills Notice above.)

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

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

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

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Participating Pharmacy is a pharmacy which has a Participating Pharmacy Agreement in effect with the pharmacy benefit manager at the time services are rendered.

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.

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

Pharmacy Benefits Manager (PBM) is the entity with which the Plan has contracted to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with the Plan.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Redwood Empire Municipal Insurance Fund Group Health Plan, which is a benefits plan for certain Employees of Redwood Empire Municipal Insurance Fund and is described in this document.

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

Plan Year is the 12-month period beginning on July 1 and ending on the following June 30.

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

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

Preventive Care Services- See page 61.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,

- 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, and

- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment,

- Is employed and supervised by a Qualified Autism Service Provider,

- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,

- 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

- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

Qualified Autism Service Provider is either of the following:

- 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

- 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 network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

Recognized Charge is the lower of:

(1) The provider's usual charge to provide a service or supply; or

(2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply; or

(3) The charge the Claims Administrator determines to be appropriate, based on factors such as:

(a) The cost of supplying the same or similar service or supply, and

(b) The manner in which the charges for the service or supply are made.

(c) The complexity of the service or supply,

(d) The degree of skill needed to provide it,

(e) The provider's specialty, and

(f) The Recognized Charge in other areas; or

(4) Another amount determined in accordance with applicable law (e.g. an amount determined through Independent Dispute Resolution under the No Surprises Act).

We may have internal data or policies that we use to determine a Recognized Charge. Such data and policies are incorporated into this Plan by reference herein and constitute binding Plan terms and conditions.

Retail Health Clinic is a facility that provides limited basic medical care services to *members* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

Retired Employee or Retiree is any former Active Employee of the Employer who retired while employed by the Employer.

Service Area is the State of California.

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

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

Specialty Medications are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified specialty drugs may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified specialty drugs will be required to be obtained through the specialty pharmacy program, unless you qualify for an exception.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means an individual who meets the plan's eligibility requirements for Spouses as outlined under ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATIONS.

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

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

Total Disability (Totally Disabled) means: In the case of a Dependent or Retired Employee, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health. In the case of an employee, Totally Disability means a person who, because of illness or

injury, is unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who is in fact unemployed.

Urgent Care means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Waiting Period is the period of time that must pass before a new hire or newly eligible employee is eligible to participate in the Plan. Each Participating Employer has its own Waiting Period guidelines, but in no circumstances will a Participating Employer's Waiting Period exceed the maximum period of 90 days allowed under federal law.

We (us, our) refers to the Plan.

You (your) refers to a Covered Person enrolled for benefits under this Plan.

PLAN EXCLUSIONS

N**ote: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact the Prescription Drug Administrator for additional information.**

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

(1) **Acupuncture.** Acupuncture treatment except as specifically stated in the "Acupuncture" provision 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.

(2) **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.

(3) **Cellular or Gene Therapies.** Cellular or gene therapies that are not set forth in the Cellular or Gene Therapies Section above.

(4) **Clinical Trials.** Services and supplies in connection with clinical trials, except as specifically stated in the "Clinical Trials" provision under the section MEDICAL BENEFITS.

(5) **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

(6) **Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL BENEFITS.

(7) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

(8) **Custodial care.** Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures,

except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL BENEFITS. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL BENEFITS.

(9) **Dental Services or Supplies.** For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth;
- Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- Services which we are required by law to cover;
- Services specified as covered in this booklet;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

(10) **Diabetic Supplies.** Prescription and non-prescription diabetic supplies, except as specifically stated in "PRESCRIPTION DRUG BENEFITS" section of this booklet.

(11) **Educational or vocational testing.** Services for educational or vocational testing or training.

(12) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge. This exclusion does not apply to inpatient care in a network Hospital, to emergency room care or to other expenses required by law to be covered by the Plan.

(13) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(14) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.

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

(16) **Food or Dietary Supplements.** Nutritional and/or dietary supplements and counseling, 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.

(17) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(18) **Foreign travel and care outside the U.S.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services unless such services or supplies are furnished in connection with Urgent Care or an Emergency Medical Condition.

(19) **Government coverage.** Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this plan.

(20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy as shown in the Summary of Benefits.

(21) **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.

(22) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(23) **Illegal Acts or Nuclear Energy.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's 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, Plan also excludes conditions that result from 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.

(24) **Infertility.** Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

(25) **Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

(26) **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition.

(27) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(28) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(29) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

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

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

(32) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission or if coverage is otherwise required by law.

(33) **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 us. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism.

(34) **Non-Medical Counseling and/or Ancillary Services**. All non-medical counseling and/or ancillary services, unless specifically included elsewhere in this Plan Document, including but not limited to alternative treatments such as homeopathy, naturopathic treatments, custodial services (see also Custodial Care above), educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis or hypnotherapy, massage therapy at a salon, aroma therapy, sleep therapy, return to work services, work hardening programs and driver safety courses.

(35) **Non-Network Providers.** For certain plans: services or supplies that are provided by a Non-Network Provider without an Authorized Referral, except Emergency Services, certain services provided by Non-Network Providers at a Network facility, Urgent Care or services otherwise required to be covered by law. See the Summary of Benefits for your plan for details.

(36) **Not Medically Necessary.** Services or supplies that are not Medically Necessary, as defined.

(37) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(38) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded. Medically Necessary non-surgical and surgical treatment of morbid obesity is covered.

(39) **Occupational.** 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.

(40) **Orthodontia.** Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL BENEFITS.

(41) **Orthopedic Supplies.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the "Orthotic Appliances" provision of MEDICAL BENEFITS.

(42) **Outpatient Occupational Therapy.** Outpatient occupational therapy, except as stated under 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 section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism.

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

(44) **Outpatient Speech Therapy.** Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision 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 section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism.

(45) **Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL 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 section MEDICAL BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

(46) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, over-the-counter humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(47) **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

(48) **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.

(49) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(50) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(51) **Routine Exams or Tests.** Routine physical exams or tests required by employment or government authority.

(52) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(53) **Specialty Drugs.** Specialty drugs that must be obtained from the specialty drug 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 drugs you get from a retail pharmacy that you should have obtained from the specialty drug program**.

(54) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(55) **Surrogacy and surrogate mother.** All charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.

(56) **Telephone, Facsimile Machine, and Electronic Mail Consultations.** Consultations provided using telephone, facsimile machine, or electronic mail, except as noted elsewhere in this Plan Document (see Online Care Services/Telemedicine in "Covered Charges" section).

(57) **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under Standard Preventive Care, including smoking deterrent products. Tobacco cessation care and treatment is otherwise excluded unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(58) **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Services" provision under the section MEDICAL BENEFITS.

(59) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance, transgender and organ transplant charges as defined as a Covered Charge.

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

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

(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.

(62) War. Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

The Plan has contracted with a Pharmacy Benefit Manager (PBM) to charge Covered Persons reduced fees for covered Prescription Drugs. The Maximum Allowable Amount is the prescription drug maximum charge for each covered drug that will be accepted by the Plan for each different type of pharmacy.

You may avoid higher out of pocket expenses by choosing a Participating Pharmacy, or by utilizing the Mail Order option whenever possible. In addition, you may reduce your costs by asking your physician and your pharmacist for the more cost-effective generic form of prescription drug.

The Maximum Allowable Amount will always be the lesser of the billed charge or the prescription drug maximum charge.

When you choose a Participating Pharmacy, the Pharmacy Benefits Manager will subtract any expense which is not covered under your prescription drug benefits. The remainder is the amount of the Maximum Allowable Amount for that claim. You will not be responsible for any amount in excess of the Maximum Allowable Amount for Covered Services of a participating pharmacy.

When the Pharmacy Benefits Manager receives a claim for drugs supplied by a Non-Participating Pharmacy, they first subtract any expense which is not covered under your prescription drug benefits, and then any expense exceeding the prescription Maximum Allowable Amount. The remainder is the amount of prescription drug covered expense for that claim.

The formulary drug list and prescription drug coverage, restrictions, and limitations are determined by the Pharmacy Benefits Manager and can change during the Plan Year.

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

Copayments and Coinsurance

After the Pharmacy Benefits Manager determines the Maximum Allowable Amount, they will apply the applicable copayment or coinsurance. The copayment or coinsurance is applied to each covered pharmacy drug or mail order drug charge and is shown in the Summary of Benefits. The copayment or coinsurance amount is not a Covered Charge under the medical Plan. Copayments and coinsurance are applied to the Covered Person's prescription drug out of pocket maximum.

Any one non-maintenance prescription is limited to a 30-day supply. Any one maintenance prescription is limited to a 90-day retail or mail order supply, unless indicated otherwise in the Summary of Benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Retail 90 Benefit Option

The Retail 90 drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Specialty Medication Program

Certain specified Specialty Medications must be obtained through the Specialty Medication Program unless you are given an exception from the Plan's Pharmacy Benefit Manager. Specialty Medications are limited to a 30 day supply and must be delivered through the mail order Specialty Pharmacy. Specialty Medications are listed in the Pharmacy Benefit Manager's formulary list, which is updated periodically.

Pharmacy Cost Containment

The Plan has adopted the Pharmacy Benefit Manager Cost Containment provisions, including: Pre-Authorizations, Quantity Limits and Step Therapy. You or your physician can initiate requests for authorizations under these programs. Each program is administered by the Pharmacy Benefits Manager, who will have the authority to approve or deny requests for authorization.

- **Prior Authorizations:** Certain specified drugs require authorization by the Pharmacy Benefit Manager prior to dispensing. You or your physician will be able to request authorization for your medication based on medical necessity.

- **Quantity Limits:** Some medications are only available at specific quantities unless authorized for higher quantities. If a prescription is written for a drug quantity exceeds the Quantity Limit, the prescription will be rejected. You or your physician will be able to request a review for authorization of the prescribed quantity.

- **Step Therapy:** Specific categories and classes of drugs require a step therapy treatment where the primary treatment option is a lower cost, effective drug. Drugs that require Step Therapy will require a Covered Person to first try the use of a primary treatment option before a secondary treatment can be authorized. You or your physician will be able to request authorization to bypass Step Therapy requirements based on medical necessity.

The Pharmacy Benefit Manager will review all requests for authorizations under the Prior Authorizations, Quantity Limits and Step Therapy programs. The Pharmacy Benefit Manager may request documentation of medical necessity from your physician.

For details on the Plan's pharmacy cost containment provisions, Covered Persons should contact the Customer Service phone number for the Pharmacy Benefit Manager listed on the back of their ID Card.

Dispense As Written (DAW) Penalty

If the Covered Person or the Covered Person's doctor requests a brand-name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, but excludes any drugs stated as not covered under this Plan.

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

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

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

Limits To This Benefit

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

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

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

Expenses Not Covered

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

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

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

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

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

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

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

(7) **Immunization.** Immunization agents or biological sera.

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

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

(10) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

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

(12) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

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

HOW TO USE YOUR PRESCRIPTION DRUG BENEFIT

When You Go to a Participating Retail Pharmacy. To identify yourself as a Covered Person, you will be issued an identification card. You must present this card to the pharmacy when you have a prescription filled. Provided you have properly identified yourself as a Covered Person, a Participating Pharmacy will only charge your Copayment or applicable coinsurance.

Generic drugs will be dispensed by the pharmacy when the prescription indicates a generic drug. When a brand name drug is specified, but a generic drug equivalent exists, the generic drug will be substituted. In certain plans, Brand name drugs will be dispensed by pharmacies when the prescription specifies a brand name and states "dispense as written" or no generic drug equivalent exists. (See the Summary of Benefits for your plan for more information.

For information on how to locate a Participating Pharmacy in your area, call the Customer Service phone number on the back of your ID card.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a prescription to a pharmacy, and the pharmacy indicates your prescription cannot be filled, or requires an additional Copayment, this is not considered an adverse claim decision. If you want the prescription filled, you will have to pay either the full cost, or the additional Copayment, for the prescription drug. If you believe you are entitled to some plan benefits in connection with the prescription drug, submit a claim for reimbursement to the pharmacy benefits manager at the address shown below:

Express Scripts, Inc.
1 Express Way
St. Louis, MO 63121
1-877-804-5393

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms and customer service are available by calling the Customer Service number on the back of your ID card. Mail your claim, with the appropriate portion completed by the pharmacist, to the pharmacy benefits manager within 90 days of the date of purchase.

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

Express Scripts, Inc.
1 Express Way
St. Louis, MO 63121
1-877-804-5393

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

Claim forms and customer service are available by calling the Customer Service number on the back of your ID card. Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase.

When You are Out of State. If you need to purchase a prescription drug out of the state of California, you may locate a participating pharmacy by calling the Customer Service number on the back of your ID card. If you cannot locate a participating pharmacy, you must pay for the drug and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Mail Order Program. You can order your prescription through the mail order prescription drug program. Not all medications are available through the mail order pharmacy. The prescription must state the drug name, dosage, directions for use, quantity, the physician's name and phone number, the patient's name and address, and be signed by a physician. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your Copayment.

When You Order Your Prescription Through the Specialty Pharmacy Program. You must order your Specialty medication through the Pharmacy Benefit Manager's Specialty Pharmacy program. The prescription must state the drug name, dosage, directions for use, quantity, the physician's name and phone number, the patient's name and address, and be signed by a physician. Your payment arrangements will be set up by the Specialty Pharmacy once your prescriptions are submitted.

PRESCRIPTION DRUG COST SAVINGS PROGRAMS

Prescription Drug Costs. The Plan has contracted with several vendors to help Members reduce the costs of high cost prescription drugs or specialty medications. The programs managed by these vendors include, but are not limited to, programs which help Members find financial assistance to cover specialty medications or sign up for drug manufacturer co-pay assistance programs and programs which work with Members and their providers to obtain prescription drugs directly from the drug manufacturer. Members who are eligible for these programs will be contacted directly by the applicable vendor with additional information. Members must follow any requirements of the program as indicated by the vendor. Additional information regarding these programs will be provided in open enrollment materials and materials provided by the vendor.

HOW TO SUBMIT A CLAIM

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

You or your provider must send properly and fully completed claim forms to the addresses listed on the back of your ID card or the Plan Administrator directly within 90 days of the date you receive the service or supply for which a claim is made. Most Network Providers will submit claims on behalf of Covered Persons electronically.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the applicable Employer's Personnel Office or Human Resources Office, or the Plan Administrator.

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

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

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care

- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

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

Medical:
Inside California Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Outside California
Submit to the local BCBS office

Prescription Drug:
Express Scripts, Inc.
1 Express Way
St. Louis, MO 63121
1-877-804-5393

Note that the No Surprises Act requires the Plan to follow a specific process for paying providers and facilities for out-of-network claims covered by the No Surprises Act, and that payment process may include an independent dispute resolution process between the Plan and your out-of-network provider. That separate payment process is applicable to the out-of-network provider -- not to you -- and is different from the claims review procedures explained in this document. You must follow the claims review procedures explained in this section to request benefits or address any benefit dispute under the Plan.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

CLAIMS & APPEALS PROCEDURES

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A “Claim” does not include a request for a determination of an individual’s eligibility to participate in the Plan.

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

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

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

A claimant must follow all Claims and Appeal procedures, both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

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

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

The definitions of the types of Claims are:

Urgent Care Claim

An Urgent Care Claim is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving Urgent Care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is an Urgent Care Claim. The Claims Administrator will defer to the attending provider's determination that the Claim is an Urgent Care Claim. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of an Urgent Care Claim, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

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

Concurrent Care Claims

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

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

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for	30 days Rescission Claims

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or pre-authorization. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

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

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	30 days

Post-Service Claim

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

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

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

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

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

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

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

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

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

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

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

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

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

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

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

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

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

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

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

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

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. The External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical

necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or the Plan's determination under Public Health Service Act Section 2499A-1 or 2799A-2 (i.e., protections against surprise medical bills for certain out-of-network services and surprise air ambulance bills under the No Surprises Act), including with respect to the Plan's determination of whether the specific services received are governed by such sections), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of Benefits Plans

The Coordination of benefits provision sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received. Coordination provisions apply separately to each Covered Person per Plan Year, and are largely determined by California law.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Maximum Allowable Amounts.

Definitions

The meanings of key terms used in this section are shown below.

Maximum Allowable Amount. For a charge to be allowable it must be a Negotiated or Recognized Charge and at least part of it must be covered under this Plan.

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

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Maximum Allowable Amount, except when another amount is required by law.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

Primary Plan. The plan that will have its benefits determined first will be the Primary Plan.

This Plan. Where the term "This Plan" is used, it will mean 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 Benefit Plans, exceed the Allowable Expenses for that plan year.

(1) If This Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any other Benefit Plan.

(2) If This Plan is not the Primary 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

Benefit plan payment order. When two or more plans provide benefits for the same Maximum Allowable Amount, benefit payment will follow these rules:

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

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

(a) The Benefit Plan which covers the person directly (that is, as an employee, or Retired Employee) ("Plan A") will pay before those of the plan which covers the person as a dependent ("Plan B"). However, if you are retired and eligible for Medicare, Medicare pays before a Benefit Plan that covers you directly (as an employee or Retired Employee.)

(b) The Benefit Plan which covers a person as an Employee who is neither laid off nor retired will pay before those of a Benefit Plan which covers that person as a laid-off or Retired Employee. The Benefit Plan which covers a person as a Dependent of an Employee who is neither laid off nor retired will pay before those of a Benefit Plan which covers a person as a Dependent of a laid off or Retired Employee. If the other Benefit Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply and the Benefit Plan which has covered you the longest will be the Primary Plan. In this case, Allowable Expense is split equally between the two plans.

(c) The Benefit Plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired will pay before those of a plan which covers the person as a COBRA beneficiary.

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

(i) The Benefit Plan of the parent whose birthday falls earlier in a year will pay before those of the Benefit Plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the Benefit Plan which has covered the parent for the longer time will pay before those of the Benefit Plan which covers the other parent.

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

(i) This rule applies when the parent with custody of the child has not remarried. The Benefit Plan of the parent with custody will pay before the Benefit Plan of the parent without custody.

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

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

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

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

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

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A, B and D, regardless of whether or not the person was enrolled under any of these parts.

Benefits for Medicare Eligible Members

For Active Employees and Family Members Enrolled Through Participating Agencies With Fewer Than 20 Employees. If you incur covered charges under this plan, we will determine our payment according to the provisions in the previous section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

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

For Active Employees and Family Members Enrolled Through Participating Agencies With At Least 20 Employees. If you are entitled to Medicare, you will receive the full benefits of this plan, except as listed below:

(a) 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

(b) You are entitled to Medicare benefits as a disabled person, unless you have current employment status as determined by Medicare rules, and one or more of

the Participating Agencies in the group has 100 or more employees (according to federal OBRA legislation).

In cases where exceptions (a) or (b) apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

For Retired Employees or Their Spouses under age 65. If you are a retired employee or the spouse of a retired employee and you are under age 65 and eligible for Medicare, your benefits under this plan will be subject to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

For Retired Employees or Their Spouses age 65 and older. If you are a retired employee or the Spouse of a retired employee and you are age 65 or older you are NOT eligible for benefits under this plan. Please consult your Human Resources Department for information on other coverage that may be available to you.

Coordinating Benefits With Medicare. Consistent with the "Benefits for Medicare Eligible Members" provision above, we 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 (subject to the terms of the "Benefits for Medicare Eligible Members" provision above):

(a) Medicare must provide benefits first to any services covered both by Medicare and under this plan.

(b) 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.

(c) For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed the Maximum Allowable Amount for the Covered Services.

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

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

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

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

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Maximum Allowable Amounts.

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Covered Person may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, "first party" underinsured or uninsured motorist coverage, worker's compensation, crime victim restitution funds, medical or disability payments, homeowner's plan, renter's plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Administrator retains sole, full and final discretionary authority to construe, apply, and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

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

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

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over <u>any</u> and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person's Recovery is less than the amount claimed, and, as a result, the

Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromise in any way the Plan's equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.

If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.

If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.

Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

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

Failure by the Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

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

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and

expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

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

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

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

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 and related sections of the Public Health Service Act (hereinafter referred to as COBRA), certain Employees and their families covered under Redwood Empire Municipal Insurance Fund Group Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Redwood Empire Municipal Insurance Fund, 2330 E. Bidwell Street, Suite 150, Folsom, CA 94530 , (707) 938-2388 x2. COBRA continuation coverage for the Plan is administered by HealthComp Administrator, P.O. Box 45018, Fresno, California 93718-5018, (800) 442-7247. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Covered Persons who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan, or enroll in coverage through the Health Insurance Marketplace. By enrolling through either of these options, you may qualify for lower costs on your monthly premiums and lower out-of- pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law,

then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner and his or her children are treated as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. This gives the Domestic Partner and children the contractual rights outlined in this Section but does not extend statutory provisions to the Domestic Partner or child.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provides at the time of the event that the Covered Person will lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in

anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) The end of a Domestic Partner's partnership with a covered Employee

(5) A covered Employee's enrollment in any part of the Medicare program.

(6) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(7) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This Plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the individual market or California Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the individual market or California Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the individual market or the California Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

Once election has been made, payment of the initial premium must be delivered to the Plan Administrator within 45 days.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Mail to:
HealthComp Administrators
P.O. Box 45018
Fresno, CA 93718

Fax to:
559-499-2464

Hand-deliver to:
HealthComp Administrators
621 Santa Fe
Fresno, CA 93721

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

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make

COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-

month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

GENERAL PROVISIONS

Providing of Care. The Plan is not responsible for providing any type of Hospital, medical or similar care, nor is it responsible for the quality of any such care received.

Independent Contractors. The Plan'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 agents of the Plan. Similarly, the Plan's employees, an employee or agent of any Hospital, medical group or medical care provider of any type are not agents of the Plan.

Non-Regulation of Providers. The benefits provided under this plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for Covered Services are regulated by the Plan's contract with Network Providers.

Out of Area Services. The Plan has contracted with Anthem to provide access to providers outside of the Plan's Service Area. Whenever a Covered Person obtains healthcare services outside of our Service Area, the claims for these services may be processed through Anthem under their contract provisions.

Non-Participating Health Care Providers Outside Plan Service Area

- **Member Liability Calculation.** When covered health care services are provided outside of California by Non-Network health care providers, the amount you pay for such services will generally be based on either Anthem's local payment or the pricing arrangements required by applicable federal or state law. In these situations, you may be liable for the difference between the amount that the Non-Network health care provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. See the Surprise Medical Bills Notice for a description of circumstances in which you will not be balance billed.

- **Exceptions.** In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment the **Plan** would make if the health care services had been obtained within California, or a special negotiated payment, as permitted under the Plan policies, to determine the amount the Plan will pay for services rendered by Non-Network health care providers. In these situations, you may be liable for the difference between the amount that the Non-Network health care provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

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

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Anthem pays all providers according to their contractual terms or as otherwise required by law.

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

Expense in Excess of Benefits. The Plan is not liable for any expense you incur in excess of the benefits of the Plan, except where required by law.

Benefits Not Transferable. Only a Covered Person is entitled to receive benefits under the Plan. The right to benefits cannot be transferred.

Workers' Compensation Insurance. The terms of the Plan do not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

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

Liability of Covered Person to Pay Providers. In accordance with California law, Covered Persons will not be required to pay any Network Provider or other health care provider any amounts the Plan owes to that provider (not including co-payments or deductibles), even in the unlikely event that the Plan fails to pay that provider. Covered Persons may be liable, however, to pay Non-Network providers any amounts not paid to them by the Plan, to the extent allowed by applicable law. See the Surprise Medical Bills Notice for a description of circumstances in which you will not be balance billed.

Conformity with Laws. Any provision of the Plan which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

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-Network 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 Anthem in consultation with you and the Non-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with Anthem.

(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 with Anthem.

(6) Performance of a surgery or other procedure that we 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 with Anthem.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not

determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Plan.

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

Continuity of Care after Termination of Provider – Legal Requirements: Subject to the terms and conditions set forth below, you may be eligible to continue care at the Network Provider level for Covered Services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider or facility at the time the provider's or facility's Network contract terminates or there is otherwise a change in the contract with that facility or provider that would terminate or result in a loss of your benefits with respect to the facility or provider, in conformance with the Consolidated Appropriations Act of 2021 ("CAA"). You may be eligible to continue care if you are a "continuing care" patient of the facility or provider at the time the facility or provider leaves the Network (or at the time the contract change is effective). This provision does not apply if the provider's or facility's contract terminates for reasons of failure to meet quality standards, medical disciplinary cause or reason, fraud, or other criminal activity.

Per the CAA, you are a "continuing care" patient if, with respect to a specific facility or provider, you are:

(1) Undergoing a course of treatment from that facility or provider for a "serious and complex condition";

(2) Undergoing a course of institutional or inpatient care from that facility or provider;

(3) Scheduled to undergo nonelective surgery from that facility or provider (including the receipt of postoperative care with respect to such surgery);

(4) Pregnant and undergoing a course of treatment for the pregnancy from that facility or provider (including immediate postpartum care); or

(5) Terminally ill (or were terminally ill) as determined under Section 1861(dd)(3)(A) of the Social Security Act, and are receiving treatment for such illness from that facility or provider.

A "serious and complex condition" is: (i) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

If the Plan Administrator determines that you may be eligible for continuing care for one of the above reasons, then the Plan Administrator will notify you and provide you with an opportunity to elect to continue care. **If you make such election**, then you may be able to continue care for up to 90 days from the date you receive the notice. Such continued transitional care would be provided under the same terms and conditions that would have applied and with respect to the items and services as would have been covered under the Plan if the termination or contract change had not occurred, with respect to the course of treatment relating to your status as a continuing care patient.

Please contact customer service at the telephone number listed on your ID card if you do not receive a notice but you think you may be eligible for continued care under this section.

Additional Eligibility for Continuation of Care after Termination of Provider: In addition to the continuity of care coverage provided per the CAA described above, you may also receive continuity of care coverage as set forth below. Anthem will provide such benefits for the completion of covered services by a terminated provider 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 Anthem 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 Plan 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.

You must be under the care of the Network 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 Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

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

The Plan or its representatives will notify you 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 Plan will request that

the terminated provider agree to accept reimbursement and contractual requirements that apply to Network Providers, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, the Plan is not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file an Appeal with us by following the procedures described in the section entitled CLAIMS AND APPEALS PROCEDURES.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Redwood Empire Municipal Insurance Fund Group Health Plan is the benefit plan of Redwood Empire Municipal Insurance Fund, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Redwood Empire Municipal Insurance Fund to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Redwood Empire Municipal Insurance Fund shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Covered Person's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FORCE MAJEURE. Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

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

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

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

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

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

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

The following members of Redwood Empire Municipal Insurance Fund's workforce are designated as authorized to receive Protected Health Information from Redwood Empire Municipal Insurance Fund Group

Health Plan ("the Plan") in order to perform their duties with respect to the Plan: the Privacy Officer, and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

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

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

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

For the purpose of identifying the source of funds from which benefits are paid under the Plan, benefits shall be deemed to come first from amounts contributed by eligible Employees and then from amounts contributed by the Employer. Employee contributions shall only be used to pay for benefits under the Plan and for Plan administrative expenses as allowed by applicable law.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the incorrect

amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured. This plan is **not** subject to the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN NAME

Redwood Empire Municipal Insurance Fund Group Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 94-2378661

PLAN EFFECTIVE DATE: July 1, 2015

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Redwood Empire Municipal Insurance Fund
2330 E. Bidwell Street, Suite 150
Folsom, CA 95630
(707) 938-2388 x2

See Appendix A for a full list of Participating Employers under the Plan.

PLAN ADMINISTRATOR

Redwood Empire Municipal Insurance Fund
233- E/ Bidwell Street, Suite 150
Folsom, CA 94530
(707) 938-2388 x2

CLAIMS ADMINISTRATOR

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
(800) 442-72447

PHARMACY BENEFITS MANAGER

Express Scripts, Inc.
1 Express Way
St. Louis, MO 63121
1-877-804-5393

Appendix A: List of Participating Employers

Redwood Empire Municipal Insurance Fund
2230 E. Bidwell Street, Suite 150 Folsom, CA 95630

City of Arcata
736 F Street
Arcata, CA 95521

City of Cloverdale
124 N. Cloverdale Boulevard
Cloverdale, CA 94525

City of Cotati
201 W. Sierra Avenue
Cotati, CA 94931

City of Eureka
531 K Street
Eureka, CA 95501

City of Fort Bragg
416 N. Franklin Street
Fort Bragg, CA 95437

City of Fortuna
621 11th Street
Fortuna, CA 95540

City of Healdsburg
401 Grove Street
Healdsburg, CA 95448

City of Lakeport
255 Park Street
Lakeport, CA 95453

City of Rohnert Park
130 Avram Avenue
Rohnert Park, CA 94928

City of Sebastopol
7120 Bodega Avenue
Sebastopol, CA 95473

City of Sonoma
No. 1 The Plaza
Sonoma, CA 95476

City of St. Helena
1572 Railroad Avenue
St. Helena, CA 94574

City of Ukiah
300 Seminary Drive
Ukiah, CA 95482

City of Willits
111 E. Commercial
Willits, CA 95490

Town of Windsor
9291 Old Redwood Highway
Windsor, CA 95492