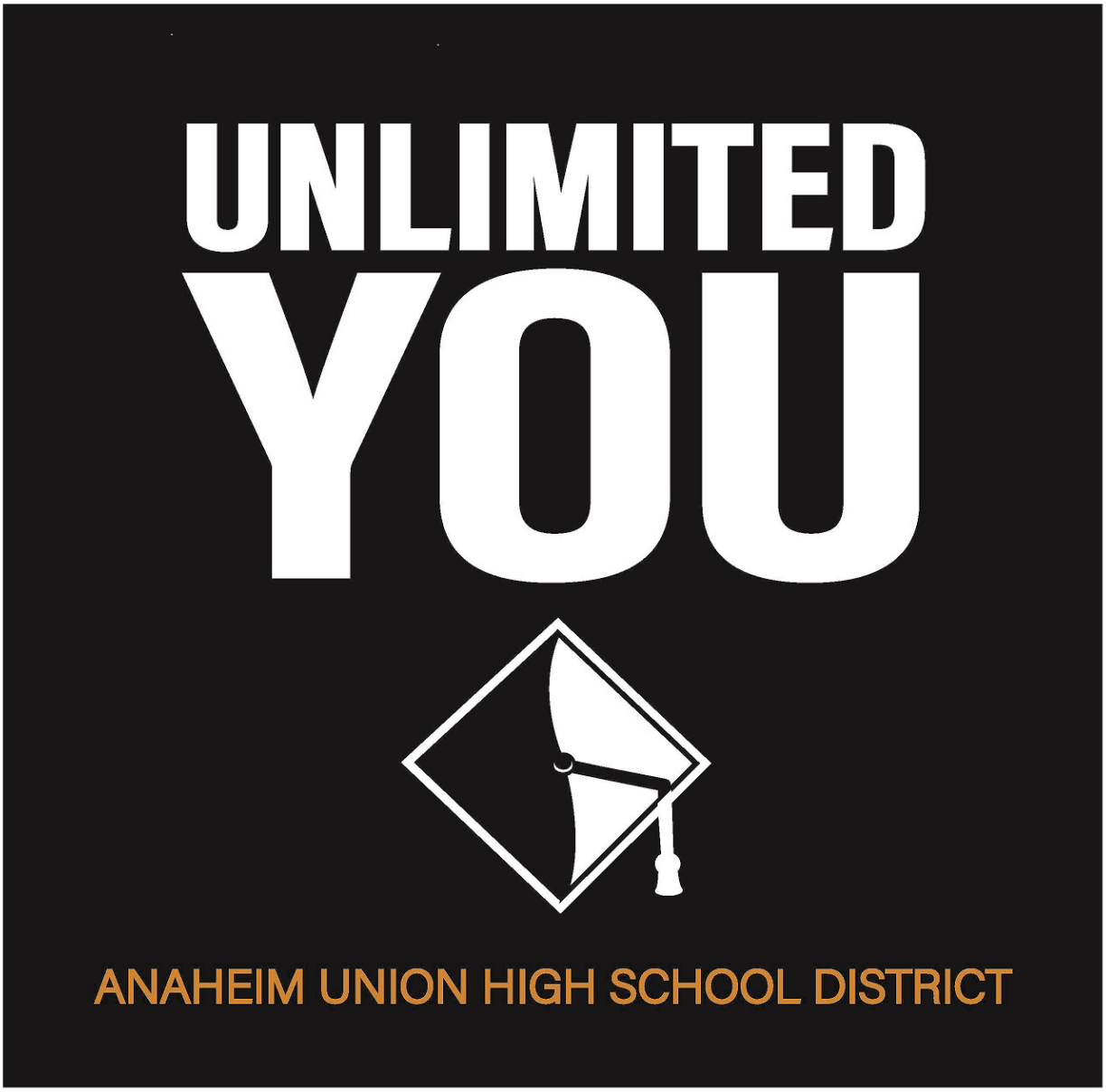

Anaheim Union High School District
Health Benefit Plan
Summary Plan Document

PPO and EPO Medical and Prescription Drug Benefits

Effective Date: 01/01/2025

Table of Contents

Introduction and Purpose

This document summarizes the benefits and limitations of the Plan and is known as the Summary Plan Document. This document will also serve as the Plan document, when a plan document is required by applicable law. The purpose of this document is to provide you and your covered Dependents, if any, with summary information on medical and prescription drug benefits available under the Anaheim Union High School District Health Benefit Plan (the "Plan") as well as information on a Covered Person's rights and obligations under the Plan. You are a valued Employee of the Anaheim Union High School District (the "Employer," "School District," or "District"), and we are pleased to sponsor this Plan to provide benefits that can help meet your health care needs.

Anaheim Union High School District is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third-Party Administrators to process claims and handle other duties for this self-funded Plan. The Third-Party Administrators for this Plan are Luminare Health Benefits, Inc (Luminare Health) for medical claims and CarelonRx for pharmacy claims. The Third-Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the cost of covered benefits through contributions, Deductibles, Co-pays, and Coinsurance amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of general assets of the Employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. Other capitalized terms are defined within the provision the term is used. When reading this Summary Plan Document (SPD), please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this group health Plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact our Risk Management / Benefits Department at (714) 999-3511 if you have questions.

Individuals covered under this Plan will be receiving an identification card that should be presented to the provider whenever services are received. On the back of the card are phone numbers to call in case of questions or problems.

Plan Overview

Eligibility and Enrollment

Eligibility and Enrollment Procedures

You are responsible for enrolling in the manner and form prescribed by your Employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from you or your Dependents in order to make these determinations. The coverage choices that will be offered to you will be the same choices offered to other similarly situated Employees.

Your Eligibility

You are eligible for benefits if you are:

- A person who is classified by the Employer on both payroll and personnel records as a permanent Employee who is guaranteed 20 or more hours per week;
- A School Board member or Personnel Commissioner;
- Determined to be a "full-time employee" under the Affordable Care Act as outlined on page 9 (see "Determining Full-time Employee Status under the Affordable Care Act (ACA)").
- An early retired Employee. That means that you:
    - Retire from active employment from the School District with a minimum of 15 years of service and you are under 65 years of age; and
    - Are eligible to retire as part of the Employer's pension plan; and
    - Elect benefits at the time of retirement. Benefits elections not chosen at the time of retirement pursuant to procedures established by the Employer cannot be elected at a later date.

For purposes of this Plan, the following classifications of workers, as determined by the Employer in its sole discretion, are not eligible for the Plan:

- Temporary or leased Employees.
- An Independent Contractor who signs an agreement with the Employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on a basis other than a regular wage or salary by the Employer.

For purposes of this Plan, eligibility requirements are used to determine a person's initial and ongoing eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with

the expectation of returning to work following the approved leave as determined by the Employer's leave policy, provided that contributions continue to be made on a timely basis. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by court, governmental agency or otherwise, without regard to whether or not the Employer agrees to such reclassification, shall change a person's eligibility for benefits.

NOTE: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing in the form required by the Plan Administrator (which may include electronic means). In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment.

Eligible Dependents

If you elect to cover yourself, you may enroll your eligible Dependents on your coverage. Your eligible Dependents include:

- Your spouse as recognized under State or Federal law including same sex spouses;
- Your domestic partner if you are in a legally State registered and valid domestic partnership;
- Your, your spouse's, or your State registered domestic partner's natural children, step children, legally adopted children, or children for whom you, your spouse, or State registered domestic partner have been appointed legal guardians by a court of law, who are:
    - Under 26 years old, or
    - Over the age of 26 and Totally Disabled, and became Totally Disabled prior to reaching age 26, and the disability is certified by a licensed physician no later than 60 days after the disabled child's 26th birthday or the newly enrolled Employee's initial enrollment period. The Plan may, in the two years after your Child turns 26, ask for proof of Total Disability at any time, after which the Plan may ask for proof of Total Disability not more than once a year. Coverage can continue for as long as the Child is deemed to be Totally Disabled under the terms of the Plan, subject to the following minimum requirements:
        - The Child must not be able to hold a self-sustaining job due to the disability; and
        - The Child must remain financially supported by the Employee/Retiree/spouse/State registered domestic partner; and
        - The Plan may request necessary documentation of financial support, including but not limited to tax returns and/or medical certification.

- A child who is considered an alternate recipient under a Qualified Medical Child Support Order or National Medical Support Notice.
- A spouse, State registered domestic partner, and child (up to age 26 unless disabled) if the Employee has enrolled in the Plan as a retiree. The Employee must elect retiree coverage for the Employee and Dependents at the time of retirement pursuant to procedures established by the Employer. Benefit elections not chosen for Dependents at the time of retirement cannot be elected at a later date.
- A spouse, State registered domestic partner, and child (up to age 26 unless disabled) if the Employee is over age 65 and has enrolled in the District-sponsored Medicare supplemental plan. The Employee must elect the District-sponsored Medicare supplemental plan at the time of eligibility for Medicare pursuant to procedures established by the Employer. Benefit elections not chosen for Dependents at the time of eligibility for Medicare cannot be elected at a later date.
- A spouse, State registered domestic partner, and child (up to age 26 unless disabled) who is currently enrolled in Plan by an Employee who was enrolled in the Plan as a retiree or was enrolled in the District-sponsored Medicare supplemental plan, and the Employee has passed.

You can enroll both as an Employee and a spouse/State registered domestic partner. If you and your spouse, or State registered domestic partner are both covered as Employees under this plan, both of you may enroll your children as family members. However, the total amounts of benefits the Plan will pay will not be more than the amount covered. Please note that not all of the benefit plans will coordinate, please refer to the Coordination of Benefits section for additional information.

An eligible Dependent does *not* include:

- A former spouse from whom you have obtained a legal separation or divorce;
- A Dependent child's spouse, a Dependent child's State registered domestic partner, or the Dependent child's State registered domestic partner's children;
- A child of a Dependent child;
- An eligible Dependent that lives outside the U.S., unless the Dependent has established his or her primary residence with you.

IMPORTANT: It is your responsibility to notify the District within 60 days if your Dependent no longer meets the criteria in this section. If, at any time, the Dependent does not meet the criteria in this section, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document for provisions regarding continuation coverage.

Proof of Dependent Eligibility

The District reserves the right to verify that your Dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a Dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible Dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your Dependent may be canceled retroactively.

Coverage for a State Registered Domestic Partner

You may cover your State registered domestic partner of the same or opposite gender under the Plan. When you enroll your State registered domestic partner, you will be required to provide proof that your partner meets certain eligibility guidelines. Required proof may include, but is not limited to:

- A declaration or equivalent document issued by the State government that shows you and your partner reside at the same address, that you are in a committed relationship, and that you and your State registered domestic partner are financially interdependent; and
- Any other documentation as may be required by the Plan Administrator to substantiate your State registered domestic partner relationship.

Taxability of Dependent Benefits

Under current tax law, you are required to be taxed on the value of health benefits provided to a Dependent who does not meet the definition of a Dependent under Code Section 152(d). The value of your State registered domestic partner's coverage will be taxable to you and treated as "imputed income." This is the term that the IRS applies to the value of any benefit or service that is considered income for the purposes of calculating your Federal taxes. The full value of coverage will be included in your pay as taxable wages (even though you do not receive the cash). Federal income tax, FICA, State, and other applicable payroll taxes will be withheld on the value of the coverage. You should consult with your tax advisor if you have questions on how this may impact your specific tax situation.

Determining Full-time Employee Status under the Affordable Care Act (ACA)

You may be eligible to participate in the Health Plan if you are considered a full-time Employee under the ACA.

You are considered a full-time Employee if you are employed, on average, at least 30 hours of service per week (or 130 hours of service in a calendar month). Full-time Employees may also elect coverage for their Dependent children up to age 26, as well as their spouse or eligible domestic partner.

The District uses a look-back measurement method to determine who is a full-time Employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations. Its purpose is to provide greater predictability for plan coverage determinations. The look-back measurement method applies to all District Employees.

The look-back measurement method involves three different periods:

1. A measurement period for counting your hours of service. If you are an ongoing Employee, this measurement period (which is also called the “standard measurement period”) runs from November 1 through October 31 and will determine your Plan eligibility for the stability period that follows the measurement period.
    - If you are a new non-seasonal Employee who is expected to work full-time, the District will determine your status as a full-time Employee who is eligible for Plan coverage based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing Employees will apply to you.

2. A stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are a full-time Employee who is eligible for coverage during the stability period.
    - Your status as a full-time Employee or a non-full-time Employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an Employee of the District. There are exceptions to this general rule for Employees who experience certain changes in employment status. The stability period runs from January 1 through December 31 following the measurement period.

3. An administrative period is a short period between the measurement period and the stability period when the District performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period lasts from November 1 through December 31 following the measurement period.

Special rules apply when Employees are rehired by the District or return from an unpaid leave. The rules for the look-back measurement method are very complex. If you have further questions, please contact the Plan Administrator.

When Coverage Begins

For You

Your coverage will begin:

- New hires: Your coverage will become effective the first day of the month following Your date of hire, or if hired on the first day of the month, coverage will be effective on that day, provided that you complete enrollment within 30 days of hire; or

- If you are eligible to enroll under the Special Enrollment Provision: Your coverage will become effective on the date set forth under the Special Enrollment Provision if application for enrollment is made within the specified period following a Special Enrollment event.

For Your Dependents

Your Dependent's coverage will be effective on the later of:

- The date your coverage with the Plan begins if you enroll the Dependent at that time; or
- The date you acquire your Dependent if application for enrollment is made within 30 days of acquiring the Dependent; or
- If your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision if application for enrollment is made within 30 days following the Special Enrollment event.

IMPORTANT: If you wait longer than 30 days after acquiring a new Dependent or a Special Enrollment event, you may not be able to enroll your Dependent until the next annual open enrollment period. Retirees can only add Dependents at the time they retire; Retirees cannot add Dependents during annual open enrollment periods.

Your Cost for Coverage

Some Employees share in the cost of your health care benefits. Each year, the District will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the costs and coverage categories available to you.

You pay your portion of this cost through payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of Dependents you cover. You must elect coverage for yourself in order to cover your eligible Dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible Employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the District to deduct any required premiums from your pay.

The elections you make will remain in effect until the end of the plan year, unless you have a

qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period.

You will automatically receive identification (ID) cards for you and your eligible Dependents when your enrollment is processed.

Annual Open Enrollment

During the annual open enrollment period, eligible Employees and Retirees who are Covered Persons will be able to enroll themselves and their eligible Dependents for coverage under this Plan. The elections you make will take effect at the beginning of the plan year and stay in effect through the end of the plan year, unless you have a qualifying change in status.

Coverage waiting periods are waived during the annual open enrollment period for covered Employees, covered Retirees, and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If you and/or your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be the month prior to the effective date. The Employer will give eligible Employees written notice prior to the start of an open enrollment period; and
- The Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage shall be January 1 following the annual open enrollment period.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. Neither the District nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the plan year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 30 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered Dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- Your marriage;
- The birth, adoption, or placement for adoption of a child;
- Your death or the death of your spouse/domestic partner or other eligible Dependent;
- Your divorce, annulment, or legal separation;
- Your termination of domestic partnership;
- A change in a Dependent child's eligibility due to age or eligibility for other coverage;
- A change in employment status for you or your spouse/domestic partner that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- A change in your work location or home address that changes your overall benefit options and/or prices;
- Employee's spouse's or domestic partner's open enrollment period differs, and Employee needs to make changes to account for other coverage;
- A significant change in coverage or the cost of coverage;
- A reduction or loss of your or a Dependent's coverage under this or another plan;
- A court order, such as a QMCSO or NMSN, that mandates coverage for an eligible Dependent child;
- Change in employment status to less than the required guaranteed 20 hours of service per week, even if reduction does not result in loss of Plan eligibility;
- Eligibility for a Special Enrollment Period to enroll in a qualified health plan through a Marketplace or seeking to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period.

If you experience a change in certain family or employment circumstances, you may be able to change your coverage. Changes must be consistent with status changes as described above. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 30 days, after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

If you decline enrollment for yourself or your Dependents (including your spouse/domestic partner) because you have other health coverage, you may be able to enroll yourself and your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the Employer stopped contributing towards your or your Dependents' other coverage).
However, you must request enrollment within 30 days after yours or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). You have 30 days to provide the required documentation to the Plan Administrator. Once approved, coverage begins the 1st of the following month.

You and/or your Dependents may enroll for health coverage under this Plan due to loss of health coverage if the following conditions are met:

- You and/or your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and
- You and/or your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health plan or health insurance policy was:
    - COBRA continuation coverage and that coverage was exhausted; or
    - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    - Terminated and no substitute coverage is offered; or
    - No longer receiving any monetary contribution toward the premium from the Employer.

You or your Dependent may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or your Dependent voluntarily canceled the other coverage, unless the current or former Employer substantially revised coverage or premium contribution level for that coverage.

In addition, if you have a new Dependent as a result of marriage, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption. If you have a new Dependent as a result of birth, you must request enrollment within 60 days after the birth. You or an affected eligible Dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This “special enrollment right” exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

Special Enrollment Provisions
Under the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009

- Employees and Dependents that are eligible but not enrolled for coverage in the Plan may enroll upon termination of the Employee or Dependent’s Medicaid or CHIP coverage or if the Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP. In both instances, the Employee must request coverage under the Plan, in writing, within 60 days after the termination or determination of subsidy eligibility. Required documentation must be submitted to the Plan Administrator. Once approved, coverage begins 1st of the following month.

Contact the California Medicaid office for further information on eligibility at www.dhcs.ca.gov/services or at 866-298-8443.

Special Enrollment as Permitted by the Affordable Care Act

If an Employee or Dependent loses eligibility in the individual market, including coverage purchased through a Marketplace (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact), the Employee or Dependent is entitled to special enrollment in this Plan if he or she is otherwise eligible for the Plan. This provision applies regardless of whether the Employee or Dependent may enroll in other individual market coverage, through or outside of a Marketplace. This special enrollment must be requested within thirty (30) days of the termination of the prior coverage. Required documentation must be submitted to the Plan Administrator. Once approved, coverage begins 1st of the following month.

When Coverage Ends

Employee’s Coverage (Applies to Active and COBRA)

Your coverage under this Plan will end on the earliest of:

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for your benefit class is canceled; or
- The last day of the month in which you tell the Plan to cancel your coverage if you are voluntarily canceling while remaining eligible due to change in status, special enrollment or at annual open enrollment periods; or
- The last day of the month in which you are no longer a member of a covered class,

as determined by the Employer except as follows:

- If you are temporarily absent from work due to an approved leave of absence for medical or other reasons, your coverage under this Plan will continue during that leave based on Board approval, provided that the applicable Employee contribution is paid when due;
- If you are on an approved leave of absence under a federal or state leave law, or are a certificated Employee permitted leave under Education Code section 44986 (refer to If you Take a Leave of Absence – FMLA, State Leave Laws, and Approved Leaves);
- If you are temporarily absent from work due to active military duty (refer to UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) section);
- If you are granted a leave of absence under the Michelle Maykin Protection Act (California Labor Code Section 1508) your coverage under the Plan will be maintained for up to 30 days for an organ transplant and up to 5 business days for a bone marrow transplant, provided that the applicable Employee contribution is paid when due; or
- The last day of the month in which your employment ends; or
- The date you submit a false claim or are involved in any other form of fraudulent act related to this Plan. Thirty-day written notice will be provided for a rescission due to fraud or misrepresentation.

Retiree's Coverage (Applies to Classes Early Retirees and Retirees)

Your coverage under this Plan will end on the earliest of the following:

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for your benefit class is canceled; or
- The last day of the month in which you tell the Plan to cancel your coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The first day of the month you turn 65 or the date the member becomes eligible for Medicare, then transfers to Medicare Supplement (if before age 65); or
- The last day of the month in which you become ineligible, as determined by Anaheim Union High School District's current Board policy; or
- The date you submit a false claim or are involved in any other form of fraudulent act related to this Plan. Thirty-day written notice will be provided for a rescission due to fraud or misrepresentation.

Your Dependent's Coverage (Applies to Active and COBRA)

Coverage for your Dependent will end on the earliest of the following:

- The end of the period for which your last contribution is made, if you fail to make any required contribution toward the cost of your Dependent's coverage when due; or
- The last day of the month in which your coverage ends, except in the event that the Employee dies, coverage for AFSCME or CSEA Dependents shall continue for four months at District expense following the death of the Employee and run concurrently with COBRA coverage, provided that the Dependent pays the contribution when due, if applicable; or
- The last day of the month in which your coverage ends; or
- The day of the month that your Dependent dies; or
- The last day of the month in which your Dependent is no longer your legal spouse due to legal separation or divorce, as determined by the law of the State where the Employee resides; or
- The last day of the month in which your Dependent no longer qualifies as a State registered domestic partner; or
- The last day of the month in which your Dependent child attains the limiting age listed under the Eligibility section, unless the child qualifies for extended Dependent coverage; or
- If your Dependent child qualifies for extended Dependent coverage as Totally Disabled, the last day of the month in which your Dependent child is no longer deemed totally disabled under the terms of the Plan; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which you tell the Plan to cancel your Dependent's coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The date you or your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan. Thirty-day written notice will be provided for a rescission due to fraud or misrepresentation.

Your Dependent's Coverage (Applies to Retirees)

Coverage for your Dependent will end on the earliest of the following:

- The end of the period for which your last contribution is made, if you fail to make any required contribution toward the cost of your Dependent's coverage when due; or
- The last day of the month in which your coverage ends, except if:
    - Your Dependent is under age 65 and you are a retiring Employee concurrently enrolled under the Medicare Supplement Plan;
- You are a Retiree and upon your death, your currently enrolled spouse or State registered domestic partner will become the primary insured. If there is no surviving spouse or State

registered domestic partner, coverage ends for any covered Dependents at the end of the month.

- The last day of the month in which your Dependent is no longer your legal spouse due to legal separation or divorce, as determined by the law of the State where the Employee resides; or
- The last day of the month in which your Dependent no longer qualifies as a State registered domestic partner; or
- The last day of the month in which your Dependent child attains the limiting age listed under the Eligibility section, unless the child qualifies for extended dependent coverage; or
- If your Dependent child qualifies for extended dependent coverage as Totally Disabled, the last day of the month in which your Dependent child is no longer deemed Totally Disabled under the terms of the Plan; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which you tell the Plan to cancel your Dependent's coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The date you or your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan. Thirty-day written notice will be provided for a rescission due to fraud or misrepresentation;
- The first day of the month in which your Dependent turns 65 unless the Dependent turns 65 on the first of the month, in which case coverage ends the first day of the previous month.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered Dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Reinstatement of Coverage

If your coverage ends due to termination of employment, leave of absence, or lay-off and you later return to active work, you will be eligible for coverage on the first of the month coinciding with or following the date of return to active work as determined by Anaheim Union High School District.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered Dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or

intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentations are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan. A determination by the Plan that a rescission is warranted will be considered an adverse benefit determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Also, coverage may be retroactively terminated to the date of your divorce or termination of domestic partnership if you fail to notify the Plan of your divorce, termination, or legal separation and you continue to cover your ex/legally separated spouse or domestic partner under the Plan. Coverage may be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered Dependent.

The Plan reserves the right to recover from you and/or your covered Dependents any benefits paid as a result of the wrongful activity which is in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered Dependents.

Coverage While Not at Work

In certain unpaid situations described in this SPD, health care coverage may continue for you and your Dependents when you are not at work, so long as you continue to pay your share of the cost. If you are not receiving your pay during an absence, you will be eligible to participate in COBRA coverage. You should discuss with Risk Management what options are available for continued coverage while you are absent from work.

If You Take a Leave of Absence – FMLA, State Leave Laws, and Approved Leaves

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the District's FMLA Policy. The Employee will be responsible for his/her share of the contribution toward these plan benefits during the approved leave period.

If you take an approved leave under a state leave law—such as the California Family Rights Act (CFRA) or the Pregnancy Disability Leave Law (PDL)—your coverage will continue for the duration of your qualifying leave under the state law, and to the extent required by state law. The Employee will be responsible for his/her share of the contribution toward these plan benefits during the approved leave period.

Under Education Code section 44986, the Board may grant a leave of absence to any certificated Employee who has applied for disability benefits for up to 39 months. If such a leave is approved, you may continue your coverage under this Plan for the duration of the approved leave, but for no longer than 39 months. You will be responsible for paying for the coverage at the rate paid by Retirees for the same coverage. At the end of the leave, if you are still determined to be disabled, you may elect to continue coverage under any available health and dental plan offered by the District. The cost of the coverage will be at the same rate paid by Retirees.

Coverage during other leaves of absence, if applicable, will be subject to the Employer's leave of absence policy. Please contact the Employer for more information.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave under USERRA, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which under the Plan run concurrently when both apply. The 24-month period starts on the date your military service begins. For more information on your rights under COBRA, see the Continuing Health Coverage through COBRA section of this SPD. For more information on your rights under USERRA, see the UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) section.

Your Medical Benefits

PPO Plan

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

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

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in-network or out-of-network. Refer to the Summary of Medical Benefits chart below for more information.

To select a physician, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the Claims Administrator shown on your ID card.

If you use in-network providers, if an in-network provider refers X-ray or laboratory services to an out-of-network provider without your knowledge or consent, those services will be paid at the in-network level of benefits.

If you use out-of-network providers — except as explained below — the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the Usual and Customary amount or Maximum Allowable Charge (see explanation below and definitions). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher coinsurance for out-of-network services, and you may be required to file claim forms. See the Summary of Medical Benefits chart below for additional information.

The No Surprises Act provides protections against “balance billing” (sometimes called “surprise billing”) in certain circumstances. See below and “Plan Provisions – Balance Billing” for more information.

If you use out-of-network providers, the No Surprises Act will apply and services will be paid at the in-network level of benefits in the following circumstances:

- If you have an emergency medical condition and receive emergency services from an out-of-network provider or facility, you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can’t be balance billed by the provider or facility for these emergency services. You will also only pay the in-network cost sharing amount for services you may get after you’re in stable condition after an emergency, unless you are provided notice and you give written consent to give up your protections not to be balanced billed for these post-stabilization services.
- If you receive services from an in-network hospital or ambulatory surgical center, and

are treated at that facility by an out-of-network provider, you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed by the provider or facility for any amount exceeding the in-network cost-sharing amount—unless you are provided notice and you give written consent to give up your protections not to be balanced billed for these out-of-network services.

- If you receive services from an in-network hospital or ambulatory surgical center, and receive the following services (referred to as "ancillary" services), you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed by the provider or facility for any amount exceeding the in-network cost-sharing amount. Ancillary services are –
    - Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner
    - Services provided by assistant surgeons, hospitalists, and intensivists
    - Diagnostic services, including radiology and laboratory services
    - Services provided by an out-of-network provider if there is no participating provider who can furnish such item or service at the facility
    - Services furnished as a result of unforeseen, urgent medical needs that arise at the time service is furnished, regardless of whether a written consent form was signed by you.
- If you receive services from an out-of-network air ambulance provider, you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles).

For more information on these exceptions, please refer to Plan Provisions – Balance Billing.

The out-of-network provider or facility providing the services described in the exceptions above will be reimbursed at a rate, and pursuant to a process, that is consistent with applicable federal regulations issued in relation to the No Surprises Act and its limitations on surprise (or balance) billing.

Your Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. Your deductible runs on a calendar year basis. Consult the Summary of Medical Benefits chart for more information.

Your medical deductible does not include:

- Any expenses not covered under the Plan;
- Prescription drug charges.

Deductible Accumulation

If you have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual deductible amount. Both in-network and out-of-network charges will apply to the deductible amount.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible for paying a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. The Summary of Medical Benefits chart below shows the coinsurance levels for common medical services in-network and out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and co-payments. It is calculated on a calendar year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and co-payments become zero for the rest of the calendar year – and the Plan pays 100% of covered expenses. See the Summary of Medical Benefits chart below for the out-of-pocket maximum amounts. Note that the out-of-pocket maximum amounts cross-apply, meaning that your out-of-pocket expenses paid for in-network services apply toward your out-of-network out-of-pocket maximum, and vice versa.

The following expenses do not apply toward your out-of-pocket maximum:

- Penalties for failing to follow pre-certification procedures;
- Any expenses not covered under the Plan;
- Prescription drug charges.

No Forgiveness of Out-of-Pocket Expenses

The Covered Person is required to pay the out-of-pocket expenses under the terms of this Plan. The requirement that you and your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied, and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

Maximum Amount or Maximum Allowable Charge

Maximum Amount and/or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Claims Administrator, taking into account and, after having analyzed at least one of the following:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The reasonable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a provider;
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a medically necessary and reasonable service.

The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Summary of Medical Benefits

PPO Plan

	In-Network	Out-of-Network
Annual Deductible *(applies to expenses below unless otherwise noted, does not apply to Prescription Drug Program)*	$325 per Individual / $1,300 family	
Annual Out-of-Pocket Maximum *(includes covered expenses under the Plan)*	$1,475 per Individual $5,900 per Family	$5,075 per Individual $20,300 per Family
Acupuncture *(medically necessary)* Limited to 52 visits per calendar year.	10% coinsurance	Not Covered
Allergy Testing, Serum, and Treatment	10% coinsurance	40% coinsurance*
Allergy Shots	10% coinsurance	40% coinsurance*
Ambulance and Other Medically Necessary Transportation: Paid by Plan after in-network deductible.	10% coinsurance	10% coinsurance
Ambulatory Surgical Center	10% coinsurance	40% coinsurance*
BRCA1/BRCA2 Testing • **Preventative** *(deductible waived for in-network)* • **Diagnostic**	No charge 10% coinsurance	40% coinsurance* 40% coinsurance*
Chiropractic Care *(medically necessary)* Limited to 52 visits per calendar year.	10% coinsurance	Not Covered
Diagnostic X-rays and Lab Services *(includes advanced radiological imaging)* • **Lab Services & X-ray** • **Imaging (CT/PET Scans, MRI's)** • **Genetic testing** *(not including medically necessary genetic testing of the fetus, or newborn, or BRCA testing; these benefits may be covered by other provisions in this Plan)*	10% coinsurance	40% coinsurance*

***Plan payments for Out-of-Network services are subject to the Usual and Customary fee allowances. When using Out-of-Network services, Covered Persons are responsible for any difference between the eligible expense and actual charges, as well as any Deductible and Coinsurance.**

	In-Network	Out-of-Network
Durable Medical Equipment *(Pre-Certification required for each DME purchase over $1,500 and DME rental over $500 a month)*	10% coinsurance	40% coinsurance*
Emergency Room / Emergency Physician Charges: *(Copayment waived if admitted, including if admitted for observation)* **Urgent Care**	10% coinsurance after $100 Co-payment 10% coinsurance	10% coinsurance after $100 Co-payment 10% coinsurance
Extended Care Facility Benefits such as Convalescent or Rehabilitation *(requires pre-certification)*	10% coinsurance	40% coinsurance*
Hearing Deficit Services Exams, Test • **Hearing Aids** (Hearing Aids: Limit one per ear, per year) • **Cochlear implant**	10% coinsurance	40% coinsurance*
Home Health Care *(requires pre-certification)* ***NOTE**: A Home Health Care Visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or up to four (4) hours of home health care services. Home Health Care is limited to 100 visits per calendar year.*	10% coinsurance	40% coinsurance*
Hospice Care *(requires pre-certification)*	10% coinsurance	40% coinsurance*
Hospital Service - • **Inpatient Services / Inpatient Physician** • **Outpatient Services / Outpatient Physician** • **Outpatient Lab and X-ray** • **Outpatient Surgery / Surgeon** ***NOTE**: Covered services provided by a Radiologist, Anesthesiologist, Pathologist, or Emergency Room Physician will be payable at the PPO level of benefits when rendered in a PPO hospital.*	10% coinsurance	40% coinsurance*

***Plan payments for Out-of-Network services are subject to the Usual and Customary fee allowances. When using Out-of-Network services, Covered Persons are responsible for any difference between the eligible expense and actual charges, as well as any Deductible and Coinsurance.**

	In-Network	Out-of-Network
Infertility	Not covered	Not covered
Maternity Benefits: *(includes physician services for prenatal visits and routine pre-natal and post-partum care, childbirth and pregnancy-related conditions)* • **Pre-natal and post-partum care** • **Doctor's Services for normal delivery or cesarean section** • **Inpatient hospital services** • **Genetic testing (when medically necessary)** *(requires pre-certification)*	10% coinsurance	40% coinsurance*
Mental Health and Substance Abuse Treatment: • **Inpatient Services / Inpatient Physician** • **Outpatient Services / Outpatient Physician** • **Intensive Outpatient / Partial Hospitalization** • **Group Therapy** • **ABA Services**	10% coinsurance	40% coinsurance*
Morbid Obesity Treatment: • **Gastric or Intestinal Bypasses** • **Stomach Stapling** • **Drugs** • **Weight Loss Programs (For Employees Only) / Lifetime Maximum: $1,000** • **Diagnostic Services** • **Nutritional Counseling**	10% coinsurance	40% coinsurance*
Physician Office Visit:	10% coinsurance	40% coinsurance*

***Plan payments for Out-of-Network services are subject to the Usual and Customary fee allowances. When using Out-of-Network services, Covered Persons are responsible for any difference between the eligible expense and actual charges, as well as any Deductible and Coinsurance.**

	In-Network	Out-of-Network
Physician Office Services: • **Charges for a Radiologist, Anesthesiologist or Pathologist** *(If Referred by A Participating Network Provider)* • **Charges for a Radiologist, Anesthesiologist or Pathologist** (*If Referred by A Non-Participating Provider)*	10% coinsurance 10% coinsurance	10% coinsurance* 40% coinsurance*
Preventive/Routine Care: • **Routine periodic and screening exams** *(deductible waived)* • **Women's Preventive Services** *(deductible waived)* • **Well-baby/Well-child Care** *(deductible waived)* • **Immunizations** *(deductible waived)* • **Eye exam** *(deductible waived)*	No charge	40% coinsurance*
Second and Third Surgical Opinion: • Paid by Plan After Deductible	10% coinsurance	40% coinsurance*
Skilled Nursing or Sub-Acute Facility *(requires pre-certification, limited to 100 days per calendar year)*	10% coinsurance	40% coinsurance*
Telehealth through LiveHealth Online	10% coinsurance	Not covered
Temporomandibular Joint Disorder Benefits: • **Diagnostic:** *(Paid by Plan after deductible)* • **Surgical Treatment:** *(Paid by Plan after deductible)* • **Non-Surgical Treatment:** *(Paid by Plan after deductible)* Maximum Benefit Per Lifetime	10% coinsurance *$1,000 (combined)*	10% coinsurance* *$1,000 (combined)*

***Plan payments for Out-of-Network services are subject to the Usual and Customary fee allowances. When using Out-of-Network services, Covered Persons are responsible for any difference between the eligible expense and actual charges, as well as any Deductible and Coinsurance.**

	In-Network	Out-of-Network
Therapy Services		
• **Aquatic Therapy**	10% coinsurance	40% coinsurance*
• **Massage Therapy**	10% coinsurance	Not Covered
• **Occupational Therapy**	10% coinsurance	40% coinsurance*
• **Physical Therapy**	10% coinsurance	Not Covered
• **Respiratory Therapy**	10% coinsurance	40% coinsurance*
• **Speech Therapy**	10% coinsurance	40% coinsurance*
All Other Covered Expenses: *(Services determined to be medically necessary and cannot be listed under Excluded Services)*	10% coinsurance	40% coinsurance*
TRANSPLANT SCHEDULE OF BENEFITS		
Transplant Services at a Non-Designated Transplant Facility (*Refer to the Transplant Benefits Section within this SPD*)	10% coinsurance	40% coinsurance*

***Plan payments for Out-of-Network services are subject to the Usual and Customary fee allowances. When using Out-of-Network services, Covered Persons are responsible for any difference between the eligible expense and actual charges, as well as any Deductible and Coinsurance.**

Prescription Drug Program

Anaheim Union High School District provides a Prescription Drug Plan as part of the medical benefit. This plan is administered by CarelonRx and consists of both retail and mail services.

Annual Prescription Out-of-Pocket Maximum A separate out-of-pocket maximum applies to Medical Benefits. Specialty Prescriptions included in the CostRelief program do not apply to the Out-of-Pocket Maximum or Medical Deductible.	$5,125 per person / $7,300 family
Generic – Tier 1	
Retail *(up to a 34 day supply)*	$10 Co-payment
Retail 90 *(up to a 90 day supply)*	$20 Co-payment
Mail Order *(up to a 90 day supply)*	$20 Co-payment
Preferred Brand – Tier 2	
Retail *(up to a 34 day supply)*	$30 Co-payment
Retail 90 *(up to a 90 day supply)*	$60 Co-payment
Mail Order *(up to a 90 day supply)*	$60 Co-payment
Non-Preferred Brand – Tier 3	
Retail *(up to a 34 day supply)*	$60 Co-payment
Retail 90 *(up to a 90 day supply)*	$120 Co-payment
Mail Order *(up to a 90 day supply)*	$120 Co-payment
Specialty Medications	Subject to the applicable Co-payment based on the Tier.*

PLEASE NOTE: If you choose to go to a pharmacy that is not in the CarelonRx network, you must pay for the prescription in full and file a claim with CarelonRx for reimbursement. CarelonRx will reimburse the billed charge minus your applicable Co-payment. Specialty Medications are not covered if an out-of-network pharmacy is used.

***Anaheim Union High School District participates in the CarelonRx' program: CostRelief, this program offers co-payment assistance for some Specialty Medications.**

PPO Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit or are not covered unless listed as an exception under the Medical Benefits Summary above.

The following are common conditions and services for which expenses are typically paid:

- **Abortions** - only if a Physician states in writing that:
    - The mother's life would be in danger if the fetus were carried to term; or
    - Is the result of rape or sexual assault; or
    - Abortion is medically indicated due to complications with the pregnancy.
- **Acupuncture** - services provided by a Licensed Acupuncturist, limited to fifty-two (52) visits per calendar year.
- **Allergy Testing and Treatment** - includes allergy testing, serum and injections as shown above.
- **Ambulance** - includes medically necessary professional ambulance services. 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. Includes charges for local ground by a professional ambulance service. Emergency ambulance services will be paid at the in-network provider level of benefits. This also includes air ambulance that is required as medically necessary.
- **Ambulatory Surgical Center** - includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Amniocentesis** - see Pregnancy.
- **Anesthesia** - includes anesthetics and the services of a licensed physician or certified nurse anesthetist (C.R.N.A.).
- **Autism Services** - ABA therapy for Mental Health, Speech and Occupational therapy recommended under ABA is covered at the same benefit levels as other services.
- **Aquatic Therapy** - see Therapy Services.
- **Birthing Center** - includes services and supplies provided by a licensed **birthing center** in connection with a covered pregnancy.
- **Blood** - includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services.

- **BRCA1 and BRCA2** - are genetic mutation tests for cancer risk. The level of benefits are paid based on whether the BRCA1 and BRCA2 tests are performed for preventive or diagnostic purposes and performed by an otherwise covered provider under the Plan.
- **Cardiac Pulmonary Rehabilitation** - when medically necessary for activities of daily living as well as a result of an Illness or Injury.
- **Cardiac Rehabilitation** - programs are covered if referred by a Physician, for patients who have:
    - Had a heart attack in the last 12 months; or
    - Had a coronary bypass surgery; or
    - A stable angina pectoris.

  Services include:
    - Phase I, while the Covered Person is an Inpatient;
    - Phase II, while the Covered Person is in a physician supervised outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the hospital.
- **Chemical Dependency** - see Substance Abuse.
- **Chemotherapy** - includes medically necessary and appropriate drugs and services of a physician or medical provider.
- **Chiropractic Care** - includes musculoskeletal manipulation by a licensed physician (M.D. or D.O.) or chiropractor (D.C.) to correct vertebral and/or joint related disorders, such as incomplete dislocation, misalignment, sprain or strain. Limited to fifty-two (52) visits per calendar year.
- **Circumcision** - and related expenses when care and treatment meet the definition of medically necessary. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.
- **Cleft Palate and Cleft Lip** - benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes medically necessary oral surgery and pre-graft palatal expander.
- **Clinical Trials and Related Care** - this plan will cover charges for any medically necessary services, for which benefits are provided by the Plan, when a participant is participating in a Phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the ACA, provided:

The clinical trial is approved by any of the following:

- The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
- The National Institute of Health;
- The U.S. Food and Drug Administration;
- The U.S. Department of Defense;
- The U.S. Department of Veterans Affairs;
- An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services;
- The research institution conducting the approved clinical trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable allowable expense, as payment in full for routine patient care provided in connection with the approved clinical trial.

Coverage will not be provided for:

- The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the approved clinical trial;
- The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an approved clinical trial;
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- A cost associated with managing an approved clinical trial;
- The cost of a health care service that is specifically excluded by the Plan;
- Services that are part of the subject matter of the approved clinical trial and that are customarily paid for by the research institution conducting the approved clinical trial.

- **Contraceptives** - this plan provides benefits for prescription contraceptives regardless of purpose. Contraceptive injections and devices administered in the physician's office will be processed under the Covered Medical Benefits in this SPD.
- **Cornea Transplants** - are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.
- **Dental Services** include:
  - The care and treatment of natural teeth and gums if an injury is sustained in an accident, excluding implants;
  - Inpatient or Outpatient Hospital charges including professional services for X-ray, lab, and anesthesia while in the hospital, if medically necessary;
  - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

- **Diabetes Treatment** - charges incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other illness.
- **Diagnostic Lab and X-ray, Outpatient** - includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests.
- **Durable Medical Equipment** - the equipment must meet the definition of Durable Medical Equipment as defined in the Definitions Section of this SPD. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a physician;
    - The equipment is subject to review under the utilization Management Provision of this SPD, if applicable;
    - The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Equipment exceed the purchase price of the item;
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless medically necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan;
    - If the equipment is purchased, benefits will be payable for subsequent repairs excluding batteries, or replacement only if required:
        - Due to the growth or development of a Dependent child;
        - When medically necessary because of a change in the Covered Person's physical condition; or
        - Because of deterioration caused from normal wear and tear;
        - The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval of the Plan.

- **Emergency Room Hospital and Physician Services** - includes medical treatment for an emergency. An emergency is an **accident** or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

Colds, sore throats, flu, and infections are examples of non-emergencies, although they may require urgent treatment.

The Plan determines which conditions and symptoms are medical emergencies using the "prudent layperson" definition of emergency. A prudent layperson is someone who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person. For example, if someone goes to the emergency room with chest pains and the situation turns out to be indigestion, a prudent layperson would agree that seeking emergency care was appropriate.

- **Extended Care Facility Services** - includes but is not limited to a rehabilitation or a convalescent facility but does not include skilled nursing or sub-acute facility (please refer to Skilled Nursing/Sub-Acute Facility). It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full-time supervision of a physician or registered nurse. In addition, the Plan requires that the facility: provide 24 hour-a-day service to include medically necessary therapies for the recovery of health or physical strength; is not a place primarily for custodial care; requires compensation from its patients; admits patients only upon physician orders; has an agreement to have a physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.
- **Foot Care (Podiatry)** - that is recommended by a physician as a result of an infection. The following charges for foot care will also be covered:
    - Treatment of corns, calluses and toenails, when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease;
    - Treatment of bunions when an open cutting operation or arthroscopy is performed;
    - Covered charges do not include Palliative Foot Care.
- **Foreign Travel Coverage** - only for emergency services.

- **Gender Dysphoria** - it is the intention of this Plan to comply with all applicable requirements of coverage regarding non-discrimination. Coverage and benefits are not affected by the sex, sexual orientation or gender identification of the member.

  Benefits for the following are covered at the same benefit levels as other services; mental health therapy; hormone therapy; and gender reassignment surgery which is medically necessary to treat the member's condition. Benefits for surgical services related to gender reassignment include: breast reduction, penectomy, orchiectomy, vaginoplasty, metoidioplasty, phalloplasty and other related procedures.

  The Plan's exclusions for services which are not medically necessary and/or cosmetic

procedures are still applicable. For example, the Plan considers chondrolaryngoplasty procedures, electrolysis, rhinoplasty, cheek implantation, lip augmentation, breast enlargement, liposuction and other facial surgeries to be cosmetic in nature and are therefore not covered benefits. (This is not an exhaustive list of excluded procedures.) If you have questions or concerns about coverage related to this benefit, please contact the Utilization Management Department for further information.

- **Genetic Testing** - when medically necessary, such as when they are performed for preventive or diagnostic purposes. In some cases, genetic testing, such as medically necessary genetic testing of a fetus or newborn, or BRCA testing, may be covered under other provisions of the Plan.
- **Hearing Deficit Services** - include:
    - Exams, tests, services and supplies for other than Preventive Care, to diagnose and treat a medical condition;
    - Purchase or fitting of ONE hearing aid per ear, per year;
    - Cochlear implants.
- **Hemodialysis Services** - includes the services of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved covered provider.
- **Home Health Care Benefits** - Home Health Care services are provided for patients who are unable to leave their home due to sickness, accidental injury, pregnancy or other covered health care condition, and as determined by the Utilization Review Organization. Covered Persons must be certified in advance before receiving services. Please refer to the Utilization Management section of this SPD for more details. Covered services that are Medically Necessary include:
    - Home visits that are in lieu of visits to the provider's office, and that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
    - Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
    - Nutrition counseling provided by or under the supervision of a registered dietitian.
    - Occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
    - Physical therapy provided under the supervision of an in-network licensed therapist.
    - Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A **Home Health Care Visit** is defined as: A visit by a nurse providing intermittent nurse services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary.

Exclusions to Home Health Care Benefits

In addition to the items listed in the Expenses Not Covered section of this SPD, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

- **Hospice Care** - treatment given at a Hospice Care Facility must be in place of a stay in a hospital or extended care facility, and can include:
  - **Assessment** - includes an assessment of the medical and social needs of the terminally ill person and a description of the care to meet those needs;
  - **Inpatient Care** - in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time home health care services;
  - **Outpatient Care** - provides or arranges for other services as related to the terminal illness, which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
- **Hospital Services (Includes Inpatient Services, Surgical Centers and Birthing Centers),** includes hospital charges for the following:
  - Room and board - For a semi-private room, charges are covered at the most common rate; for a private room in a hospital with semi-private rooms, charges are covered only up to the hospitals most common semi-private room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense;
  - Services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
  - Services of nursing staff and other hospital staff providing care;
  - Emergency room services; and
  - Medically necessary services.

An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.

- **Hospital Services (Outpatient).**
- **Infant Formula** - administered through a tube as the sole source of nutrition for the Covered Person.
- **Massage Therapy** - see Therapy Services
- **Maternity** - see Pregnancy
- **Medical Supplies** - includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines** - includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Health** - coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.
- **Morbid Obesity Treatment** - includes only the following treatments if those treatments are determined to be medically necessary and appropriate for an individual's Morbid Obesity condition. Refer to the Definitions Section of this SPD for a definition of Morbid Obesity.
    - Gastric or intestinal bypasses;
    - Stomach stapling;
    - Prescription medication needed for weight loss;
    - Physician supervised weight loss programs at a medical facility for Employees only. Services include Physician office visits and laboratory tests;
    - Charges for diagnostic services;
    - Nutritional counseling by a registered dietician.

  This Plan does not cover diet supplements, exercise equipment or any other items listed in the Expenses Not Covered section of this SPD.
- **Nursery and Newborn Expenses Including Circumcision** - are covered for the following Children of the covered Employee or covered spouse/domestic partner: natural (biological) Children and newborn Children who are adopted or placed for adoption at the time of birth. Expenses for the covered newborn will be processed under the mother’s benefits for the first 30 days following the delivery. If the newborn needs to stay in the Hospital longer than the mother following the delivery, those charges will be processed under the newborn’s benefits subject to the Deductible and other Plan provisions, including HIPAA Special Enrollment.

- **Nutritional Counseling** - includes counseling services by a licensed or approved provider for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.
- **Occupational Therapy** - see Therapy Services
- **Oral Surgery** includes:
    - Excision of partially or completely impacted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.
- **Orthotic Appliances, Devices and Casts** - including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings and braces.
- **Oxygen and its Administration**
- **Physical Therapy** - see Therapy Services
- **Pregnancy** - includes prenatal visits and routine pre-natal and post-partum care, routine ultrasounds, one amniocentesis test for genetic testing, hospital stays, and obstetric services provided by a doctor.

  Maternity benefits may be provided even if the pregnancy began before covered under the Plan, as long as coverage is in effect when the pregnancy ends. If expenses are incurred after coverage ends, no benefits will be paid.

  Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section in accordance with the Newborns' and Mothers' Health Protection Act. A provider automatically will receive authorization from the Plan for prescribing a length of stay that does not exceed these time frames. The mother and newborn's attending physicians, only after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours. Pre-certification is required for any extended hospital stay.

- **Preventive / Routine Care Services** - covers routine preventive care services as defined by the United States Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, (CDC), and Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines. Additional preventive care and screenings for women are covered as defined by the Health and Human Services Health Plan Coverage Guidelines for Women's Preventive Services.

  Coverage includes but is not limited to:
  - Routine physicals, which include medical history, physical exam, prostate exam, colonoscopy, weight/height, blood pressure, cholesterol screening, urinalysis, blood glucose, and EKG, as medically appropriate;
  - Routine gynecological exam and pap smear;
  - Routine mammogram;
  - Breast cancer genetic test counseling (BRCA) for women at higher risk;
  - Well baby/well child care; and
  - Immunizations;
  - Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy.

- **Private Duty Nursing Services** - when outpatient care is required 24 hours a day due to medical necessity.
- **Prosthetics** - prosthetic devices (other than dental) to replace all or part of an absent body organ or part while eligible under this plan, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance.
- **Radiation Therapy** - includes radium and radioactive isotope therapy.
- **Reconstructive Surgery** - includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed. Reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

- **Skilled Nursing / Sub-Acute Facility** - coverage limited to 100 days per calendar year includes, but is not limited to, a skilled nursing or sub-acute facility. It does not include rehabilitation or convalescent facilities (please refer to Extended Care Facility Services). It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full-time supervision of a physician or registered nurse. In addition, the Plan requires that the facility: provide 24 hour-a-day service to include skilled nursing care and medically necessary therapies for the recovery of health or physical strength; is not a place primarily for custodial care; requires compensation from its patients; admits patients only upon physician orders; has an agreement to have a physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the State in which it operates and provides the services under which the licensure applies.

  Covered Services include:

  - A room with two or more beds;
  - Special treatment rooms;
  - Regular nursing services;
  - Laboratory test;
  - Short Term Therapy (physical, occupational, speech, or respiratory);
  - Drugs or medicine given during your stay. This includes oxygen.
  - Blood Transfusion.
  - Needed medical supplies and appliances.
- **Sleep Disorders / Sleep Studies**
- **Second and Third Surgical Opinion** - must be given by a Board-certified Specialist in the medical field relating to the surgical procedure being proposed. The physician providing the second opinion must not be affiliated in any way with the physician who rendered the first opinion.
- **Speech Therapy** - see Therapy Services
- **Sterilization (Voluntary)**
- **Substance Abuse** - coverage for mental health treatments are treated the same as benefits provided for other medical conditions.

- **Surgery and Assistant Surgeon Services** - if determined medically necessary by the Plan. For Multiple or Bilateral Procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. In-network claims will be paid according to the network contract. For out-of-network claims, the industry guidelines are to allow the full Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.
- **Telehealth** - telephone or internet consultations – offered through LiveHealth Online.
- **Temporomandibular Joint (TMJ) Disorder Services** include:
    - Diagnostic services;
    - Surgical Treatment;
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension). Non-surgical treatment is limited to $1,000 lifetime.
    - Services provided by a non-network provider may be covered at in-network coinsurance percentage based on Usual & Customary fee allowances.
- **Therapy Services** - therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:
    - **Aquatic therapy** by a qualified physical therapist;
    - **Massage therapy** by a qualified in-network chiropractor or in-network physical therapist;
    - **Occupational therapy** by a qualified occupational therapist;
    - **Physical therapy** by a qualified in-network physical therapist;
    - **Respiratory therapy** by a qualified respiratory therapist;
    - **Speech therapy** by a qualified speech therapist.

- **Transgender Services** - **s**ervices and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a doctor. 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, medical management and exclusions for cosmetic services, except as specifically stated in this provision. 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.

  The Plan will also pay for certain travel expenses incurred in connection with an

approved transgender surgery, when the hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by the Plan.

The Plan will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion.

- Ground transportation to and from the hospital when it is 75 miles or more from your place of residence;
- Coach airfare to and from the hospital when it is 300 miles or more from your residence;
- Lodging, limited to one room, double occupancy;
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded.

Important: You must obtain approval from The Plan in advance in order for travel expenses to be covered.

- **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.
- **Vision Care Services** (Refer to Vision Care section of this SPD).
- **Weight Loss Programs** (Refer to Morbid Obesity section of this SPD).
- **Wigs** covered for medical related hair loss.
- **X-ray Services** for covered benefits.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

PPO - Expenses Not Covered

Exclusions, including complications from excluded items are not considered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, even if deemed to be medically necessary, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the injury or illness to treatment listed in the Covered Medical Benefits section when the Plan has information that the illness or injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

Abortions - unless a Physician states in writing that:

- The mother's life would be in danger if the fetus were to be carried to term; or
- Is the result of rape or sexual assault; or
- Abortion is medically indicated due to complications with the pregnancy.

Acts of War - injury or illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

Acupuncture Treatment - services rendered by an out-of-network provider are not covered.

Administrative Costs - that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date - that are incurred by the participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alternative / Complimentary Treatment - includes treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

Appointments Missed - an appointment the Covered Person did not attend.

Assistance with Activities of Daily Living.

Assistant Surgeon Services - unless determined medically necessary by the Plan.

Augmentation Communication Devices - and related instruction or therapy.

Before Enrollment and After Termination - services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

Bereavement Counseling.

Biofeedback Services - except when covered under the Mental Health Benefit section.

Blood - blood donor expenses.

Blood Pressure Cuffs / Monitors.

Cardiac Rehabilitation - beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

Chelation Therapy - except in the treatment of conditions considered medically necessary, medically appropriate and not experimental or investigational for the medical condition for which the treatment is recognized.

Chiropractic - services rendered by an out-of-network provider.

Claims - received later than 18 months from the date of service.

Claim Form Completion - charges for completion of a claim form.

Complications of Non-Covered Services - that are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons - that are for services, supplies, and/or treatment of any participant that were incurred while confined and/or arising from confinement in a prison, jail or other penal institution.

Cosmetic Treatment, Cosmetic Surgery - or any portion thereof, unless the procedure is otherwise listed as a covered benefit or medically necessary.

Counseling Services - in connection with financial or marriage counseling.

Court-Ordered - any treatment or therapy that is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

Criminal Activity - any Injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Custodial Care - as defined in the Definition Section of this SPD.

Dental Services

- The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to hospital charges including professional charges for X-ray, lab and anesthesia, or for charges for treatment of injures to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw that was fractured or dislocated in an accident;

- Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances;

Dental implants including preparation for implants;

Developmental Delays - occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions. Speech and occupational therapies recommended under ABA are covered.

Duplicate Services and Charges or Inappropriate Billing - including the preparation of medical reports and itemized bills.

Education or Training Program - services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Environmental Devices - environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers or vacuum devices.

Examinations - examinations for employment, insurance, licensing or litigation purposes.

Excess - that are for charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be reasonable or medically necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental or Investigational - service, supplies, medicines, treatment, facilities or equipment that the Plan determines are Experiment or Investigational.

Extended Care - any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.

Family Planning - consultation for family planning.

Fitness Programs - general fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or bodybuilding.

Foot Care (Podiatry):

- Routine foot care;
- Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet.

Foreign Travel - outside of the United States if travel is for the sole purpose of obtaining medical services.

Government - that the Participant obtains, but which is paid, may be paid, is provided or

could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government (other than the District); or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities - that meet the following requirements:

- That are furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
- That can be paid for by any government agency other than the District, even if the patient waives his rights to those services or supplies.

NOTE: *This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.*

Hearing Deficit Services - implantable hearing devices; however, this exclusion does not include Cochlear implants.

Home Births - and associated costs.

Home Modifications - modifications to your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

Infertility Services include:

- Charges for diagnostic services. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions;
- Fertility tests;
- Tests and exams done to prepare for induced conception;
- Surgical reversal of a sterilized state that was a result of a previous surgery;
- Sperm enhancement procedures;
- Direct attempts to cause pregnancy by any means including, but not limited to, hormone therapy or drugs;
- Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT);
- Embryo transfer;
- Freezing or storage of embryo, eggs or semen;
- Drugs.

Lamaze Classes - or other childbirth classes.

Learning Disability - special education, remedial reading, school system testing and other

rehabilitation treatment for a learning disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

Liposuction - regardless of purpose.

Maintenance Therapy - such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

Mammoplasty or Breast Augmentation - unless covered elsewhere in this document.

Maintenance Therapy - such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

Mammoplasty or Breast Augmentation - unless covered elsewhere in this document.

Massage Therapy - unless provided by a qualified in-network chiropractor or in-network physical therapist.

Medicare - that are provided, or which would have been provided had the participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled “Coordination of Benefits” and “Medicare”.

Military Service - that are related to conditions determined by the Veteran’s Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments - that are charged solely due to the participant having failed to honor an appointment.

Nocturnal Enuresis Alarm (Bed wetting).

Non-Custom-Molded Shoe Inserts.

Non-Prescription Drugs - that are for drugs for use outside of a hospital or other inpatient facility that can be purchased over-the-counter and without a physician’s written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Non-Professional Care - medical or surgical care that is not performed according to generally accepted professional standards.

Not Medically Necessary - services, supplies, treatment, facilities or equipment that the Plan determines are not medically necessary.

Not Acceptable - that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Covered Provider - that are performed by Providers that do not satisfy all the

requirements per the Provider definition as defined within this Plan.

Not Specified As Covered - that are not specified as covered under any provision of this Plan.

Nursery and Newborn Expenses - for grandchildren of a covered Employee or spouse/domestic partner.

Nutritional Supplements - all enteral feedings, supplemental feedings, over-the-counter electrolyte supplements and related supplies including feeding tubes, pumps, bags and products.

Orthopedic Shoes - orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Other than Attending Physician - other than those certified by a physician who is attending the participant as being required for the treatment of injury or disease and performed by an appropriate provider.

Over-the-Counter Medication, Products, Supplies or Devices - unless covered elsewhere in this SPD.

Panniculectomy / Abdominoplasty - unless determined by the Plan to be medically necessary.

Personal Comfort - services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

Physical Therapy - services rendered by an out-of-network provider.

Prescription Medication - which is administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that require a physician's Prescription.

Prior to Coverage - that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prognathic and Maxillofacial Surgery.

Prohibited by Law - to the extent that payment under this Plan is prohibited by law.

Reconstructive Surgery - performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the Plan, unless covered elsewhere in this SPD.

Return to Work / School - telephone or internet consultations or completion of claim forms or forms necessary for the return to work or school.

Reversal of Sterilization - procedures or treatments to reverse prior voluntary sterilization.

Room and Board Fees - when surgery is performed other than at a hospital or surgical Center.

Self-Administered Services - or procedures that can be done by the Covered Person without the presence of medical supervision.

Self-Inflicted - that are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Services at No Charge or Cost - services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

Services - that should legally be provided by a school.

Services Provided by a Close Relative - see Definition of a **Close Relative** in the Definitions section of this SPD.

Sex Therapy.

Sexual Function - diagnostic services, non-surgical and, surgical procedures and prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

Speech Therapy - for mental, emotional or nervous disorders unless specified as ABA therapy for Mental Health, Speech and Occupational therapy.

Surrogate Motherhood or Gestational Carrier Services - including any services or supplies provided in connection with a surrogate pregnancy and maternity charges incurred by a Covered Person acting as a surrogate mother.

Taxes - sales taxes, shipping and handling unless covered elsewhere in this SPD.

Third-Party Liabilities - any covered expenses to the extent of any amount received from others for the bodily injuries or losses that necessitate such benefits. “Amounts received from others” specifically include, without limitation, liability insurance, worker’s compensation, uninsured motorists, underinsured motorists, “no-fault” and automobile medical payments, and homeowner’s insurance.

Transportation - transportation services, which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's physician.

Travel - travel, whether or not recommended by a Physician, except as specifically provided herein.

Unreasonable - that are not “Reasonable” and are required to treat Illness or Injuries arising from and due to a Provider’s error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vision Care - unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

Vitamins, Minerals and Supplements - even if prescribed by a physician, except for Vitamin B-12 injections that are prescribed by a physician for medically necessary purposes or as covered under the Federally-required preventive care benefit.

Vocational Services - vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for injury prevention education or return-to-work programs.

War / Riot - incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the participant is a member of the armed forces of any country, or during service by a participant in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

Weight Reduction - services or supplies for obesity, weight reduction or dietary control.

Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving, or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

Worker's Compensation - charges for treatment of any illness or injury that is covered by a Worker's Compensation law or legislation or sustained in the course of any occupation for wages or profit except for the owner or partner who has expressly been excluded from the Worker's Compensation policy.

NOTE: With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the injury if the injury results from being the victim of an act of domestic violence or a documented medical condition.

This Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

EPO Plan

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

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

If you use in-network providers, the Plan pays a percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or Claims Administrator may require you to do so.

If an in-network provider refers X-ray or laboratory services to an out-of-network provider without your knowledge or consent, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan does not provide medical coverage for services provided by out-of-network Providers, except as explained below.

The No Surprises Act provides protections against “balance billing” (sometimes called “surprise billing”) in certain circumstances. See below and “Plan Provisions – Balance Billing” for more information.

If you use out-of-network providers, the No Surprises Act will apply and services will be paid at the in-network level of benefits in the following circumstances:

- If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can’t be balance billed by the provider or facility for these emergency services. You will also only pay the in-network cost sharing amount for services you may get after you’re in stable condition after an emergency, unless you are provided notice and you give written consent to give up your protections not to be balanced billed for these post-stabilization services.
- If you receive services from an in-network hospital or ambulatory surgical center, and are treated at that facility by an out-of-network provider, you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can’t be balance billed by the provider or facility for any amount exceeding the in-network cost-sharing amount—unless you are provided notice and you give written consent to give up your protections not to be balanced billed for these out-of-network services.
- If you receive services from an in-network hospital or ambulatory surgical center, and receive the following services (referred to as “ancillary” services), you will pay only

the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed by the provider or facility for any amount exceeding the in-network cost-sharing amount. Ancillary services are -

  - Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner
  - Services provided by assistant surgeons, hospitalists, and intensivists
  - Diagnostic services, including radiology and laboratory services
  - Services provided by an out-of-network provider if there is no participating provider who can furnish such item or service at the facility
  - Services furnished as a result of unforeseen, urgent medical needs that arise at the time service is furnished, regardless of whether a written consent form was signed by you.

- If you receive services from an out-of-network air ambulance provider, you will pay only the in-network cost-sharing amount (such as copayments, coinsurance, and deductibles).

For more information on these exceptions, please refer to Plan Provisions – Balance Billing.

The out-of-network provider or facility providing the services described in the exceptions, above, will be reimbursed at a rate, and pursuant to a process, that is consistent with applicable federal regulations issued in relation to the No Surprises Act and its limitations on surprise (or balance) billing.

Your Co-payment

Some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. Co-payments may apply regardless of whether the deductible has been satisfied. Please refer to the Summary of Medical Benefits chart for any required co-payments and if the deductible may need satisfied before co-payments are applied.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and co-payments. It is calculated on a calendar year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and co-payments become zero for the rest of the calendar year and the Plan pays 100% of covered expenses. See the Summary of Medical Benefits chart below for the out-of-pocket maximum amounts.

The following expenses do not apply toward your out-of-pocket maximum:

- Penalties for failing to follow pre-certification procedures;
- Any expenses not covered under the Plan;
- Out-of-network charges.
- Infertility Diagnosis – Testing Only.

Out-of-Pocket Accumulation

If you have family coverage, any combination of covered family members can help meet the annual maximum family out-of-pocket, up to each person's individual out-of-pocket amount.

Maximum Amount or Maximum Allowable Charge

"Maximum Amount" and/or "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Claims Administrator, taking into account and, after having analyzed at least one of the following:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The reasonable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider;
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a medically necessary and reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Summary of Medical Benefits

EPO Plan

	In-Network
Annual Deductible	$0 per person / $0 family
Annual Out-of-Pocket Maximum *(includes covered expenses under the Plan combined with Prescription Drug Coverage)*	$2,000 per person / $4,000 family

Ambulance	
Air, Ground and Water Transport • **Base charge and mileage** • **Disposable supplies** • **Monitoring, EKG's, or ECG's, cardiac defibrillation, CPR, oxygen, and IV solutions**	No Charge
Dental Care **(Covered based upon medical necessity, see Dental Care under Eligible Expenses)**	
Inpatient Hospital Services *(Pre-certification required)*	No Charge
Outpatient Hospital or Surgery Center	No Charge
General Anesthesia	No Charge
Emergency Care for accident injury to natural teeth	No Charge
Orthognathic surgery	No Charge
Dental or orthodontic services for cleft palate	No Charge

Diabetes	
Equipment and supplies used for the treatment of diabetes, to include: • **Blood Glucose Monitors** • **Insulin Pumps** • **Pen delivery system for insulin administration *(non-disposable)*** • **Visual aids *(but not eyeglasses)* to help the visually impaired to properly dose insulin**	No Charge See Medical Equipment
Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications	No Charge See Prosthetic Devices
Diabetes education program services supervised by a doctor, to include: • **Teaching you and your family about the disease process and care** • **Training, education, and nutrition therapy to enable you to use equipment supplies, and medicines needed to manage the disease**	$25 Co-payment
Insulin, glucagon, insulin syringes, disposable pen delivery system, lancets, and other drugs for treatment of diabetes	See Prescription Drugs
Doctor Care *(or services of a Health Professional)*	
Physician Office Visit	$25 Co-payment
Specialist Office Visit	$25 Co-payment
Home Visit	$25 Co-payment
Surgery in hospital, surgery center or medical group and surgical assistants	No Charge
Anesthesia Services	No Charge
Doctor's visit during a hospital stay	No Charge
Telemedicine	$25 Co-payment

General Medical Care (*In a Non-Hospital Based Facility)*	
Hemodialysis treatment, including treatment at home, if approved	No Charge
Medical Social Services	No Charge
Chemotherapy	No Charge
Radiation Therapy	No Charge
Infusion therapy, including but not limited to Parental Therapy and Total Parental Nutrition (TPN)	No Charge
Allergy Test and Care	$25 Co-payment
X-ray and laboratory test: • **Advanced imaging procedures**	$100 Co-payment per test
X-ray and laboratory test: • **Genetic testing** *(not including medically necessary genetic testing of the fetus, or newborn, or BRCA testing; these benefits may be covered by other provisions in this Plan)* • **All Other X-ray and laboratory test**	No Charge
Smoking cessation programs for nicotine dependency *(see Prescription Drug coverage for prescription and over the counter smoking cessation products)*	No Charge
Hearing Aid Services	
Hearing Aids	No Charge (One per ear, every 3 years)
Cochlear Implants	No Charge
Audiological Evaluations	No Charge
Visit for fitting, counseling, adjustments and repairs	No Charge (within one year of receiving a covered hearing aid)

Home Health Care *(The Plan will cover home health care furnished by a home health agency (HHA) for up to 100 visits in a calendar year)*	
Care from registered nurse, or licensed vocational nurse working under the supervision of a registered nurse or doctor	$25 Co-payment/visit
Occupational, Physical, Respiratory, or Speech Therapy	$25 Co-payment/visit
Visit with a medical social services worker	$25 Co-payment/visit
Home health aide working under the supervision of a registered Nurse with the home health agency	$25 Co-payment/visit *(one visit equals four hours or less)*
Medically Necessary Supplies from the Home Health Agency	No Charge
Hospice Care *(Pre-Certification Required)*	
Interdisciplinary team to develop and maintain plan of care	No Charge
Short term inpatient hospital care for crisis or respite care.	No Charge
Occupation, Physical, Respiratory and Speech Therapy	No Charge
Social Services and Counseling Service	No Charge
Skilled Nursing Services given by or under the supervision of a registered nurse.	No Charge
Certified home health aide services and homemaker services given under the supervision of a registered nurse.	No Charge
Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation	No Charge
Volunteer Services given by trained hospice volunteers and directed by a hospice staff member	No Charge
Drugs and medicines prescribed by a doctor	No Charge
Medical supplies, oxygen and respiratory therapy supplies.	No Charge
Care which controls pain and relieves symptoms	No Charge
Bereavement Services	No Charge

Infertility and Birth Control	
Diagnosis and testing for infertility	50% coinsurance *(not tracked toward the out-of-pocket maximum)*
Sterilization for females	No Charge*
Sterilization for males	$100 Co-payment
Family Planning Services	$25 Co-payment
Shots and Implants for Birth Control	No Charge*
Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a doctor	No Charge*
Doctors Services to prescribe, fit and insert and IUD or diaphragm	No Charge*
**Certain contraceptives and related services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.*	
Inpatient Hospital Services *(Pre-Certification Required)*	
Semi-Private Hospital Room *(Private room is covered only when medically necessary)*	No Charge
Operating Room and Special Treatment Room	No Charge
Special Care Unit	No Charge
Nursing Care	No Charge
Blood Transfusions	No Charge
Laboratory, cardiology, pathology and radiology services	No Charge
Physical Therapy, Occupational Therapy, Speech Therapy, Radiation Therapy, Chemotherapy and Hemodialysis provided during your stay	No Charge
Drugs and medicines, and supplies you get during your stay; this includes oxygen	No Charge

Medical Equipment and Supplies	
Durable Medical Equipment *(Pre-Certification required for each DME purchase over $1,500 and DME rental over $500 a month)*	No Charge
Special Food Products for treatment of phenylketonuria (PKU)	No Charge
Pediatric Asthma Equipment and Supplies • **Nebulizers, including face masks and tubing** • **Inhaler spacers and peak flow meters** • **Pediatric asthma education program services to help you use the items listed above**	No Charge $25 Co-payment
Prosthetic Devices	No Charge
Mental Health / Substance Abuse	
Hospital Services • **Acute Inpatient** (pre-certification required) • **Partial Hospitalization** • **Residential Treatment** • **Intensive Outpatient Treatment**	No Charge
Office Visits • **Licensed Clinical Social Worker, Psychologist, Psychiatrist, etc.** • **Group Therapy** • **ABA Specialist**	$25 Co-payment
Outpatient *(Hospital or Surgery Center)*	
Emergency Room • **Use of room, supplies and other services, including oxygen, drugs and medicine**	$150 Co-payment *(waived if admitted, including if admitted for observation)*
Outpatient Surgery • **Operating Room use, supplies, including oxygen, drugs and medicines provided during the procedure / stay**	$150 Co-payment

Pregnancy or Maternity Care	
Initial Diagnostic Office Visit, Physician Charge	$25 Co-payment
Doctor's services for normal delivery or cesarean section	No Charge
Hospital Services • **Inpatient services** • **Outpatient services** *(Pre-certification is required if the stay exceeds 48 hours for vaginal delivery, or 96 hours for a cesarean section)*	No Charge
Genetic Testing *(when medically necessary)*	No Charge
Prenatal testing administered by the State Department of Public Health for the California Prenatal Screening Program	No Charge
Hospital services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled member	No Charge
NOTE: *Certain services for Pregnancy are covered under the "Preventive Care Services" benefit.*	
Preventive Care Services	
Preventive Care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable State law. This means preventive care services are covered with no deductible (if applicable) or copayment when you use an in-network provider.	
Full physical exams and periodic check-ups including well-woman visits	No Charge
Vision or Hearing Screenings *(By Medical Doctor, see Vision Care benefit for services provided by an Optometrist, Ophthalmologist, etc.)*	No Charge
Immunizations	No Charge
Health Education provided by a Medical Doctor	No Charge
Health Screenings *(please see description of covered services listed in Eligible Expenses – under Preventative Care Services)*	No Charge
Preventive Services for high-risk population as determined by a Medical Doctor based on clinical expertise	No Charge

HIV testing, regardless of whether testing is related to a primary diagnosis	No Charge
Preventive care and screening for women *(see description of Covered Services listed in Eligible Expenses – under Women's Preventative Care and Screening)*	No Charge

Skilled Nursing Facility Services *(Up to 100 days per calendar year / Pre-Certification Required)*	
Semi-private room	No Charge
Special treatment rooms	No Charge
Nursing services	No Charge
Laboratory test	No Charge
Physical, Occupational, Respiratory, and Speech Therapy Services	No Charge
Drugs and medicines given during your stay	No Charge
Blood Transfusions	No Charge
Needed medical supplies and appliances	No Charge
Therapy Services – Rehabilitative Care *(Medically Necessary)*	
Acupuncture	$25 Co-payment
Cardiac Rehabilitation	$25 Co-payment
Chiropractic Care	$25 Co-payment
Physical Therapy	$25 Co-payment
Occupational Therapy	$25 Co-payment
Speech Therapy	$25 Co-payment
Limited to 52 visits; combined with acupuncture, chiropractic, and physical therapy. Occupational therapy, speech therapy, and cardiac rehabilitation visits are not limited. This restriction does not apply in circumstances of treatment for ABA recognized therapies.	

Transplant Services *(Pre-Authorization Required – See Eligible Expenses)*	
Transplant Services (*Refer to the Transplant Benefits Section within this SPD*)	Co-payment based upon the type of service provided.
Urgent Care	
Urgent Care Facility • **Doctor's Services** • **Supplies, including oxygen** • **Drugs and medicines provided during the visit** • **Care given when a surgery is done. This includes operating room use, supplies, drugs and medicine, oxygen, and other services.**	$25 Co-payment

Prescription Drug Coverage Anaheim Union High School District provides a Prescription Drug Plan as part of the medical benefit. This plan is administered by CarelonRx and consists of both retail and mail services.	
Deductible	None
Out-of-Pocket Maximum	$2,000 per Individual $4,000 Family (Combined with Medical Plan)
Prescription Drug Coverage Benefits apply to in-network and out-of-network providers.	
Generic – Tier 1	$10 Co-payment
Retail *(up to a 34-day supply)*	$20 Co-payment
Retail 90 *(up to a 90-day supply)*	$20 Co-payment
Mail Order *(up to a 90-day supply)*	
Preferred Brand – Tier 2	
Retail *(up to a 34-day supply)*	$30 Co-payment
Retail 90 *(up to a 90-day supply)*	$60 Co-payment
Mail Order *(up to a 90-day supply)*	$60 Co-payment
Non-Preferred Brand – Tier 3	
Retail *(up to a 34-day supply)*	$60 Co-payment
Retail 90 *(up to a 90-day supply)*	$120 Co-payment
Mail Order *(up to a 90-day supply)*	$120 Co-payment
Specialty Medications	Subject to the applicable Co-payment based on the Tier. *

PLEASE NOTE: If you choose to go to a pharmacy that is not in the CarelonRx network, there is no coverage under this plan.

***Anaheim Union High School District participates in the CarelonRx' program: CostRelief, this program offers co-payment assistance for some Specialty Medications. Specialty Prescriptions included in the CostRelief program do not apply to the Plan Out-of-Pocket Maximum.**

EPO Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit or are not covered unless listed as an exception under the Medical Benefits Summary above.

The following are common conditions and services for which expenses are typically paid:

- **Abortion** - services to include elective and medically necessary procedures.
- **Acupuncture** - services provided by a Licensed Limited to fifty-two (52) visits per calendar year, maximum combined with Chiropractic and Physical Therapy Services.
- **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. Ambulance services are covered when one or more of the following criteria are met:

  For ground ambulance, you are transported:
  - From your home, or from the scene of an accident or medical emergency, to a hospital;
  - Between hospitals, including when you are required to move from one hospital that does not contract with the Plan to one that does; or
  - Between a hospital and a Skilled Nursing Facility or other approved facility.

  For air or water ambulance, you are transported:
  - From the scene of an accident or a medical emergency to a hospital;
  - Between hospitals, including when you are required to move from one hospital that does not contract with us to one that does; or
  - Between a hospital and another approved facility.

  Non-emergency ambulance services are subject to medical necessity reviews by the Plan. Emergency ground ambulance services do not require pre-service review. When using an air ambulance in a non-emergency situation, the Plan reserves the right to select the air ambulance provider.

  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.

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

Hospital to Hospital Transport - if you are being transported from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health if the hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain hospitals. For services to be covered, you must be taken to the closest hospital that can treat you.

- **Anesthesia** - includes anesthetics and the services of a licensed physician or certified nurse anesthetist (C.R.N.A.)
- **Autism Services** - ABA therapy for Mental Health, Speech and Occupational therapy recommended under ABA is covered at the same benefit levels as other services.
- **Bereavement Services** - include assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse/domestic partner, children, step-children, parents, brothers and sisters) for up to one year after the Employee's or covered family member's death.
- **Blood Transfusions** - includes the cost of blood, blood products or blood processing.
- **Cardiac Rehabilitation** - see Therapy Services.
- **Chemical Dependency** - see Mental Health / Substance Abuse.
- **Clinical Trials** - routine patient costs, as described below, for an **approved clinical trial** will be covered based on the type of service provided.

  Coverage is provided for routine patient care costs you receive as a participant in an **approved clinical trial**. The services must be those that are listed as covered by this Plan for members who are not enrolled in a clinical trial.

  Routine patient care costs include items, services, and drugs provided to you in connection with an **approved clinical trial** that would otherwise be covered by the Plan.

  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:

- 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 supports 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.
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- Studies or investigations done for drug trials that are exempt from the investigational new drug application.

All requests for clinical trials services, including requests that are not part of **approved clinical trials**, will be reviewed according to the Plan's Clinical Coverage Guidelines, related policies and procedures.

Routine patient costs do not include any of the costs associated with any of the following:

- The investigational item, device, or service;
- 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;
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

NOTE: You will pay for costs of services that are not covered.

- **Dental Care**
    - **Inpatient hospital services** are limited to 3 days when the stay is:
        - Needed for dental care because of other medical problems you may have;
        - Ordered by a doctor (M.D.) or a dentist (D.D.S. or D.M.D);
        - Approved by the Plan.
    - **General anesthesia and facility services** when dental care must be provided in an outpatient hospital or surgery center.
        - **These services are covered when:**
        - You are less than seven years old;
        - You are developmentally disabled; or
        - Your health is compromised, and general anesthesia is medically necessary.
    - **Emergency care for accidental injury to natural teeth**
        - The care is not covered if you hurt your teeth while chewing or biting unless the chewing or biting results from a medical or mental condition.
    - **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.
    - **Cleft Palate** means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. Coverage includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

  Important: If you decide to receive dental services that are not covered under this Plan, a dentist who participates in the network may charge you his or her usual and customary rate for these 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 service.

- **Foreign Travel Coverage** - only for emergency services.

- **Hearing Aid Services**

  The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from: an otolaryngologist; or, a State-certified audiologist.

  Services include:
  - 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 the plan benefits for office visits to doctors.
  - Hearing aids (monaural or binaural) including:
    - Ear mold(s), the hearing aid instrument; and
    - Batteries, cords and other ancillary equipment.
  - Visits for fitting, counseling, adjustments and repairs for a one-year period after receiving covered hearing aid.
  - Cochlear implants.

- **Home Health Care** - services will be covered when furnished by a home health agency, up to 100 visits in a calendar year.

- **Hospice Care** - services provided for the palliative care of pain and other symptoms if you have an illness that may lead to death. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Your doctor will work with the hospice care to develop the care plan.

  Respite Care - is provided on an occasional basis for up to five consecutive days per admission.

- **Hospital Services** - include hospital charges for the following:
  - Room and board - For a semi-private room, charges are covered at the most common rate; for a private room in a hospital with semi-private rooms, charges are covered only up to the hospital's most common semi-private room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense;
  - Operating room and special treatment room;
  - Special care units;
  - Blood transfusions. This includes the cost of blood, blood products or blood processing;
  - Laboratory, cardiology, pathology and radiology services;
  - Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
  - Services of nursing staff and other hospital staff providing care;

- Emergency room services; and Drugs and medicines, and supplies you get during your stay. This includes oxygen.

An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.

- **Infertility and Birth Control** - benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women and contraceptive coverage for women are covered under the “Preventive Care Services” benefit.
- **Mastectomy**
  - Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema;
  - Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy.
- **Medical Equipment and Supplies**
  - Special Food Products and formulas that are part of a diet prescribed by a doctor for the treatment of phenylketonuria (PKU). You can get most formulas used in the treatment of PKU from a drugstore; these are covered under you Plan’s benefits for prescription drugs. Special food products that are not available from a drugstore are covered as medical supplies under your Plan’s medical benefits;
  - Durable Medical Equipment – equipment and supplies that are rented or purchased if they are: ordered by your primary care doctor, used only for the health problem, used only by the person who needs the equipment or supplies, and made only for medical use;
- **Mental Health Conditions / Substance Abuse** - coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.

- **Morbid Obesity Treatment** - includes only the following treatments if those treatments are determined to be medically necessary and appropriate for an individual's Morbid Obesity condition. Refer to the Definitions section of the SPD for a definition of Morbid Obesity.
    - Gastric or intestinal bypasses;
    - Stomach stapling;
    - Prescription medication needed for weight loss;
    - Physician supervised weight loss programs at a medical facility for Employees only. Services include physician office visits and laboratory tests;
    - Charges for diagnostic services;
    - Nutritional counseling by a registered dietician.

  This Plan does not cover diet supplements, exercise equipment or any other items listed in the Expenses Not Covered section of this SPD.

- **Nutritional Counseling** - includes counseling services by a licensed or approved provider for treatment of eating disorders such as anorexia nervosa, bulimia nervosa and diabetes.
- **Occupational Therapy** - see Therapy Services.
- **Organ and Tissue Transplants** - services and supplies are given if:
    - You are receiving the organ or tissue; or
    - You are the organ or tissue donor, if the person who is receiving it is a member of this plan. If you are not a member, the benefits are lowered by any amounts paid by your own health plan.
- **Pregnancy / Maternity Care** - medical services for an enrolled member are provided for pregnancy and maternity care, including the following services: Prenatal, postnatal, and postpartum care, ambulatory care services (including ultrasounds, fetal non-stress tests, doctor office visits, and other medically necessary maternity services performed outside of a hospital), involuntary complications of pregnancy, diagnosis of genetic disorders in cases of high-risk pregnancy, and inpatient hospital care including labor and delivery.
    - **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.
- **Preventive Care Services**
    - **Counseling and intervention services,** as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including sexually transmitted infections, human immunodeficiency virus (HIV), contraception, and smoking cessation counseling.
    - **Health Screenings include:** mammograms, breast cancer genetic test counseling (BRCA) for women at higher risk, Pap test and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer

screenings, and other medically accepted cancer screening test, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity. This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at no charge.

- **Prosthetics** - prosthetic devices (other than dental) to replace all or part of an absent body organ or part while eligible under this Plan, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Coverage includes, but is not limited to;
    - Surgical implants;
    - Artificial limbs or eyes;
    - Breast prosthesis following a mastectomy;
    - Prosthetic devices to restore a method of speaking when required as a result of laryngectomy;
    - The first pair of contact lenses or eye glasses when needed after a covered and medically necessary eye surgery;
    - Therapeutic shoes and inserts designed to treat foot complications due to diabetes;
    - Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient;
    - Colostomy supplies;
    - Supplies needed to take care of these devices.
- **Reconstructive Surgery** - reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a medically necessary mastectomy. This also 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.
- **Skilled Nursing / Sub-Acute Facility** - coverage limited to 100 days per calendar year includes, but is not limited to, a skilled nursing, rehabilitation, convalescent or sub-acute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full-time supervision of a physician or registered nurse. In addition, the Plan requires that the facility: provide 24 hour-a-day service to include skilled nursing care and medically necessary therapies for the recovery of health or physical strength; is not a place primarily for custodial care; requires compensation from its patients; admits patients only upon physician orders; has an agreement to have a physician's services available when needed; maintains adequate medical records for all patients; has a written transfer

agreement with at least one Hospital and is licensed by the State in which it operates and provides the services under which the licensure applies. Covered Services include:

- A room with two or more beds;
- Special treatment rooms;
- Regular nursing services;
- Laboratory test;
- Short Term Therapy (physical, occupational, speech, or respiratory);
- Drugs or medicine given during your stay. This includes oxygen;
- Blood Transfusion;
- Needed medical supplies and appliances.

- **Smoking Cessation** - includes expenses for smoking cessation program for members that are 18 and older that are FDA approved and recommended by the United States Preventive Service task force.

- **Speech Therapy** - see Therapy Services.
- **Telehealth, Telephone or Internet Consultations** - offered through LiveHealth Online.
- **Therapy Services** - **Rehabilitative Care** - You may have up to 52 visits; combined with acupuncture, chiropractic, and physical therapy. Occupational therapy, speech therapy, and cardiac rehabilitation visits are not limited. Massage therapy is not covered.

  Rehabilitative care as described above is also provided for a member who is being treated for a severe mental disorder or for pervasive development disorder or autism. This care is provided even though the member may not have suffered an illness or injury.

- **Transgender Services** - **s**ervices and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a doctor. 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, medical management and exclusions for cosmetic services, except as specifically stated in this provision. 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.

  The Plan will also pay for certain travel expenses incurred in connection with an approved transgender surgery, when the hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by the Plan.

  The Plan will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion.

- Ground transportation to and from the hospital when it is 75 miles or more from your place of residence;
- Coach airfare to and from the hospital when it is 300 miles or more from your residence;
- Lodging, limited to one room, double occupancy;
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded.

Important: You must obtain approval from The Plan in advance in order for travel expenses to be covered.

- **Wigs** - covered for medical related hair loss.
- **Women's Preventive Care and Screening**
  - FDA-approved contraceptive drugs, devices, and other products for women, including over-the-counter items, if prescribed by your doctor. This includes contraceptive drugs, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal;
  - At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by your doctor, the prescribed FDA-approved form of contraception will be covered as preventive care under this section;
  - In order to be covered as preventive care, contraceptive drugs must be either a generic or single source brand name drug (those without a generic equivalent). Multi-source brand name drugs (those with a generic equivalent) will be covered as preventive care services when medically necessary according to your attending doctor, otherwise they will be covered under your Plan's prescription drug benefits, (see Prescription Drugs);
  - Breastfeeding support, supplies, and counseling. One breast pump will be covered per pregnancy;
  - Gestational diabetes screening;
  - Preventive prenatal care;
  - Screening for iron deficiency anemia in pregnant women;
  - Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation.

For More Information - If you have a question about a covered service or need more information about a specific procedure or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

EPO Expenses Not Covered

Some health care services are not covered by the Plan. These include, but are not limited to, any charge for care, supplies, or services:

Ambulance services are not covered when:

- Another type of transportation can be used without endangering your health;
- Services are provided for your convenience or the convenience of your family members or a doctor;
- You do not use the air-ambulance selected in a non-emergency situation;
- Used as transportation to a doctor's office;
- Used as transportation to a morgue or funeral home;
- Air ambulance services that are provided when ground or water ambulance are medically appropriate will not be covered;
- Air ambulance transfers from one hospital to another because you, your family, or your doctors prefer a specific hospital or doctor.

Acts Of War - injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

Acupressure - acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

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

Birth Control Devices - any devices needed for birth control which can be obtained without a doctor's prescription, such as condoms. This does not apply to FDA-approved over the counter contraceptive methods for women that are prescribed by a doctor, as specifically stated in 'Preventive Care Services' under the Eligible Expenses section.

Blood - benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services - for straightening the teeth (orthodontic services) except as specifically stated in 'Reconstructive Surgery' and 'Dental Care' Covered Services.

Care Not Covered - services received before you were on the Plan, or after your coverage ended; even if payments have been pre-determined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Care Not Listed - services not listed as being covered by this Plan.

Care Not Needed - any services or supplies that are not medically necessary.

Claims - received later than 18 months from the date of service.

Clinical Trials - services and supplies in connection with clinical trials, unless specifically stated in 'Clinical Trials' under the Eligible Expenses section.

Confined Persons - that are for services, supplies, and/or treatment of any participant that were incurred while confined and/or arising from confinement in a prison, jail or other penal institution.

Cosmetic Surgery - surgery or other services done only to make you:

- Look beautiful;
- To improve your appearance; or
- To change or reshape normal parts or tissues of the body

This does not apply to reconstructive surgery you might need to:

- Give you back the use of a body part;
- Have for breast reconstruction after mastectomy;
- Correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance.

Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Court-Ordered - any treatment or therapy that is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

Crime or Nuclear Energy - any health problem caused: (1) while you were committing or trying to commit a felony as long as any injuries were not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

Criminal Activity - any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such Injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Custodial Care or Rest Cures - room and board charges for a hospital stay mostly for a change of scene or to make you feel good, services given by a rest home, home for the aged, or similar facility, (includes care for your 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 giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

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

Dental Services or Supplies - dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Examinations - examinations for employment, insurance, licensing or litigation purposes.

Exercise Equipment - exercise equipment, or any charges for fitness programs. This includes charges such as those from a physical fitness instructor, health club or gym, even if your doctor advises you to change your lifestyle.

Excess - charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be reasonable or medically necessary, in the Plan Administrator's discretion, in accordance with the Plan terms as set forth by and within this document.

Experimental or Investigative - service, supplies, medicines, treatment, facilities or equipment that the Plan determines as experimental or investigational. But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization (See 'How to Appeal a Claim').

Eye Exercises or Services and Supplies for Correcting Vision - optometry services, eye exercises, and orthoptics, except for eye exams to find out if your vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects - any eye surgery just for correcting vision.

Fitness Programs - general fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or bodybuilding.

Foreign Travel - travel outside of the United States if travel is for the sole purpose of obtaining medical services.

Gene Therapy - gene therapy as well as any drugs, procedures or health care services related to it that introduce or is related to the introduction of genetic material if not a person intended to replace or correct faulty or missing genetic material.

Hearing Deficit Services:

- Surgically implanted hearing devices (i.e. audient bone conduction devices); however, this exclusion does not include Cochlear implants;
- Charges for a hearing aid which is not determined to be medically necessary or for more than one hearing aid per ear every 3 years;
- Charges for a hearing aid which exceeds specification prescribed for the correction of hearing loss.

Immunizations - needed to travel outside the U.S.

Infertility Services - any infertility treatment including artificial insemination, in vitro fertilization, and sperm banks.

Lifestyle Programs - programs to help you change how you live, like fitness clubs or dieting programs. This does not apply to cardiac rehabilitation programs approved by the Plan.

Massage Therapy.

Medical Equipment, Devices and Supplies - this Plan does not cover the following:

- Supplies provided only for:
    - Your comfort or hygiene;
    - Exercise;
    - Making the room or home more comfortable, such as air conditioning or air filters.
- Replacement or repair of purchased or rental equipment because of misuse, abuse or loss/theft;
- Surgical supports, corsets or articles of clothing, unless needed to recover from surgery or injury;
- Enhancements to standard equipment and devices that are not medically necessary;
- Supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is medically necessary in your situation;
- This exclusion does not apply to medically necessary treatment as specifically stated in Durable Medical Equipment in the Covered Services Section.

Medicare - that are provided, or which would have been provided had the participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled “Coordination of Benefits” and “Medicare”.

Nicotine Use - programs to stop smoking or the treatment of nicotine or tobacco use if the program is not affiliated with the Plan.

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 doctor, except as specifically provided or arranged by the Plan.

Non-Prescription Drugs - that are for drugs for use outside of a hospital or other inpatient facility that can be purchased over-the-counter and without a physician’s written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Orthopedic Shoes - 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.

Outpatient Drugs - outpatient prescription drugs or medications including insulin except for abortion or contraception when taken in the doctor's office. (See Prescription Drugs for what is covered).

Personal Care and Supplies - services for your personal care, such as: help in walking, bathing, dressing, feeding or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Private Contracts - services or supplies provided pursuant to a private contract between the member and a provider, for which the 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.

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

Routine Exams - routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp or sports program.

Services Given by Provider Who Are Not In-Network - the Plan will not cover these services unless they are previously approved by the Plan, except for emergency or out-of-area Urgent Care.

Services Not Needing Payment - services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

Services Received Outside of the United States - services rendered by providers located outside the United States, unless the services are for emergencies, emergency ambulance services and Urgent Care.

Sexual Problems - treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal - surgery done to reverse an elective sterilization.

Surrogate Mother Services - for any services or supplies provided to a person not covered under the Plan in connection with a surrogate pregnancy, including but not limited to, the bearing of a child by another woman for an infertile couple.

War / Riot - incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the participant is a member of the armed forces of any country, or during service by a participant in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

Weight Change Programs - Inpatient and Outpatient.

Services, programs, or supplies for losing or gaining weight: these include but are not limited to:

- Dietary evaluations and counseling;
- Exercise programs;
- Behavioral modification programs;
- Surgery;
- Laboratory test; and
- Food and food supplements, vitamins and other nutritional supplements, associated with weight loss or weight gain.

But the Plan will cover this kind of medically necessary care if:

- It is for the treatment of anorexia nervosa or bulimia nervosa; or
- The treatment is for morbid obesity. (Surgical treatment of morbid obesity will be covered only when the Plan's Medical Policy rules are met).

Worker's Compensation - charges for treatment of any illness or injury that is covered by a Worker's Compensation law or legislation or sustained in the course of any occupation for wages or profit except for the owner or partner who has expressly been excluded from the Worker's Compensation policy.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

Plan Provisions

Balance Billing

In the event that a claim submitted by an in-network or out-of-network provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions in certain circumstances (except as described below), and the Plan has no control over out-of-network providers that engage in balance billing practices.

In addition, with respect to services rendered by an in-network provider being paid in accordance with a discounted rate, it is the Plan's position that the participant should not be responsible for the difference between the amount charged by the in-network provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any in-network provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the in-network provider.

Balance Billing – No Surprises Act

A new federal law—the No Surprises Act—places restrictions on the ability of health care providers and facilities to balance bill you when you receive certain services. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, or when you are transported by air ambulance, you are protected from balance billing. In these cases, you should not be charged more than the Plan's copayments, coinsurance, or deductible.

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, like a copayment, coinsurance, or a deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your Plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with the Plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what the Plan pays 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 deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

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 they can bill you is your plan's in- network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

- **Air Ambulance** - if you receive air ambulance services from a provider that is out-of-network, the most the air ambulance provider may bill you is the Plan's in-network cost-sharing amount.

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have these 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 any additional costs to out-of-network providers and facilities directly.

- Generally, the Plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as 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 in-network deductible and out-of-pocket limit.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- Burns;
- Coma;
- Inpatient confinement expected to exceed 14 days;
- Multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- Neonatal birth;
- Organ transplant;
- Progressive neurological debilitative disease;
- Certain psychiatric conditions;
- Quadriplegic/paraplegic conditions;
- Stroke; and
- Multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

Claims Audit

In addition to the Plan's Medical Record Review process, the Claims Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Claims Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or medically necessary and reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the usual and customary and reasonable amounts or other applicable provisions, as outlined in this SPD.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a usual and customary and reasonable charge, in accordance with the terms of this SPD.

Cooperation

Circumstances may arise in which the Employer, Plan Administrator, or Claims Administrator may require you to provide information or pay an amount that directly or indirectly relates to participation in, or benefits paid or payable from the Plan. In consideration of the coverage provided by the Plan, you must fully cooperate, provide any and all information requested, execute any and all documents that will enable the Employer, the Plan Administrator, or the Claims Administrator to access such information, and pay any amount due pursuant to the Plan. In the event you fail to cooperate or provide false information in response to such request, payment of all benefits under the Plan may be suspended and/or coverage may be terminated in the Employer's sole discretion to the extent permitted by applicable law, and Employer, the Plan Administrator, or the Claims Administrator may pursue any other remedy available to it for any loss incurred by it as a result of the failure to cooperate or make payment, or the provision of false information.

Pre-certification

Pre-certification is advance approval and sometimes, determination of the medical necessity and appropriateness, of services, and the appropriate length of stay, if applicable. You and your covered Dependents are required to obtain pre-certification for those services identified in the section “Services Requiring Pre-Certification” under the “Utilization Management” section. In some cases, the in-network provider may obtain the pre-certification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to pre-certify, you must call the number listed on the back of your ID card to pre-certify an admission or treatment:

- At least 2 weeks prior to any scheduled or non-emergency hospital admission or treatment;
- Within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Pre-certification - Pregnancy and Childbirth

Pre-certification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. The Utilization Review Organization must also be notified before any hospital admission for complications that occur during the pregnancy.

Penalty for Noncompliance with Pre-certification

If pre-certification requirements are not met, any expenses incurred will not be covered. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied, and benefits will not be paid beyond the number of days considered medically necessary.

The pre-certification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied, and you may file an appeal of the denial through the Plan’s appeal process.

Continuity of Care

A “continuing care patient” whose health care provider or facility leaves the Plan’s network is entitled to 90 days of coverage at in-network rates after the provider or facility leaves the network.

A continuing care patient is an individual who with respect to a health care provider or facility -

- Is undergoing a course of treatment for a “serious and complex condition” (could be acute or chronic);

- Is undergoing a course of institutional or inpatient care;
- Is scheduled to undergo nonelective surgery, including postoperative care;
- Is pregnant and undergoing a course of treatment for the pregnancy; or
- Is or was determined to be terminally ill and is receiving treatment.

Transplant Benefits (Non-Designated)

Refer to the Utilization Management section of this SPD for certification requirements.

Definitions

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Definitions section of the SPD for additional definitions.

Approved Transplant Services - services and supplies for certified transplants when ordered by a physician. Such services include, but are not limited to, hospital charges, physician's charges, organ and tissue procurement, tissue typing and ancillary services.

Organ and Tissue Acquisition / Procurement - means the harvesting, preparation, transportation and the storage of human organ and tissue, which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant - includes autologous, allogenic, and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

Benefits

The Plan will pay for covered expenses incurred by a Covered Person for an illness or injury, subject to any deductibles, coinsurance amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's negotiated rate.

It will be the Covered Person's responsibility to obtain prior certification for all transplant related services. If prior certification is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be considered medically necessary and medically appropriate for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

Covered Expenses

The Plan will pay for approved transplant services for organ and tissue acquisition/procurement and transplantation if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or stem cell transplant, the cost of organ and tissue acquisition/procurement from a living human or cadaver, will be included as part of the Covered Person's covered expenses when the donor's own plan does not provide coverage for organ and tissue acquisition/procurement. This includes the cost of

donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or injuries are not covered unless the donor is a Covered Person on the Plan.

The Plan will also pay for certain travel expenses incurred in connection with an approved transplant surgery, when the hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by the Plan. The Plan will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed $10,000 per transplant surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion.

- Ground transportation to and from the hospital when it is 75 miles or more from your place of residence;
- Coach airfare to and from the hospital when it is 300 miles or more from your residence;
- Lodging, limited to one room, double occupancy;
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded.

Important: You must obtain approval from The Plan in advance in order for travel expenses to be covered.

Benefits are payable for the following transplants:

- Kidney;
- Kidney/Pancreas;
- Pancreas, which meets the criteria as determined by the Plan;
- Liver;
- Heart;
- Heart/Lung;
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions;
- Small Bowel.

Transplant Exclusions

In addition to the items listed in the Expenses Not Covered section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan;
- Expenses for organ and tissue acquisition/procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a

condition for which there would be approved transplant services;

- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan;
- Transplants considered experimental, investigational or unproven;
- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured;
- Autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for the treatment of but not limited to:
    - Testicular cancer;
    - Brain tumors of any kind (including but not limited to gliomas, astrocytomas, rhabdomyosarcomas, and peripheral neuroectodermal tumors);
    - Sarcomas;
    - Lung cancers;
    - Ovarian, uterine and cervical cancer;
    - Malignant melanoma and other skin cancer;
    - Cancer of the genitourinary tract including but not limited to prostate and bladder cancer;
    - Peripheral neuroepithelioma;
    - AIDS;
    - Gastrointestinal tract cancer including esophagus, gastric, small intestine, colon;
    - Cancer of the pancreas;
    - Patients with brain metastases;
    - Head and neck cancer;
    - Sickle cell anemia;
    - Immune thrombocytopenic purpura;
    - Multiple sclerosis.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered medically necessary and/or appropriate, as determined by the Plan;
- Expenses related to, or for, the purchase of any organ.

Vision Care Benefits

The Plan will pay for covered expenses for vision care incurred by a Covered Person, subject to any required deductible, co-payment if applicable, participation amount, maximums and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, maximum fee schedule or the negotiated rate.

Covered Benefits

- Eye exam;
- Protective lenses following cataract or aphakia surgery.

Exclusions

Benefits will NOT be provided for any of the following:

- Refraction;
- Lenses;
- Frames;
- Contacts;
- Safety lenses and frames;
- Eye surgeries used to improve/correct eyesight for refractive disorders including lasik surgery, radial keratotomy, refractive keratoplasty or similar surgery;
- Sunglasses or subnormal vision aids;
- The fitting and/or dispensing of non-prescription glasses or vision devices whether or not prescribed by a Physician or optometrist;
- Vision therapy services or supplies;
- Orthoptics (eye exercise) services or supplies;
- Correction of visual acuity or refractive errors;
- Aniseikonia.

Livongo

The Plan offers you and your family members, at no cost, the opportunity to participate in the Livongo program, which includes Livongo for Diabetes and Livongo for Hypertension. Livongo's program uses advanced technology and personalized coaching to help you manage diabetes and high blood pressure. The Livongo for Diabetes program makes living with diabetes easier by providing you with a connected blood glucose meter, unlimited strips, and coaching, as well as an easy-to-use mobile app that tracks your readings, gives you a personalized report, and allows you to order refills. Certified Diabetes Educators are available to provide nutrition, weight loss, and lifestyle tips when you need it most. Similarly, the Livongo for Hypertension program simplifies living with high blood pressure by providing you with the same level of personalized coaching and a connected blood pressure monitor that syncs to a mobile app to track your numbers. Both programs provide you a way to conveniently manage your conditions and keep you up-to-date with tips on how to stay well, and you can choose to send a report to your doctor of your readings.

Utilization Management
And Other Medical Management Services

Utilization Management
The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for utilization management are not satisfied. Covered Person should call the phone number on the back of the Plan identification card to request pre-certification at least three weeks prior to the scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

SPECIAL NOTE: The Covered Person will not be penalized for failure to obtain pre-certification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis should contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care of hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of notification.

Utilization Review Organization
The Utilization Review Organization for Inpatient, Outpatient, Radiology, and Mental Health is:

ANTHEM BLUE CROSS OF CALIFORNIA
PO BOX 60007
LOS ANGELES, CA 90060-0007
(800) 274-7767

Definitions
The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Definitions section of this SPD for additional definitions.

Certified or Certification for the purpose of hospital admission for giving birth means notification to the Utilization Review Organization of the upcoming need for medical treatment and where services will be provided. For all other purposes, Certification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is medically necessary for the care and treatment of an illness or injury.

Utilization Management means an assessment of the facility in which the treatment is being provided. Except in the case of inpatient stay in a hospital or birthing center for the purpose of giving birth, it also includes a formal assessment of the medical necessity, effectiveness, and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment) or retrospective basis (following treatment).

Services Requiring Pre-Certification

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stay in a Hospital or Extended Care Facility;
- Organ and tissue transplants;
- Home Health Care;
- Durable Medical Equipment over $1,500 or any Durable Medical Equipment rentals over $500/month;
- Prosthetics;
- All Inpatient stays for Mental Health Disorders, substance use and chemical dependency treatment;
- Behavioral health treatment for Pervasive Developmental Disorder or autism;
- Partial hospitalization programs, intensive outpatient programs and transcranial magnetic stimulation (TMS);
- Applied Behavioral Analysis (ABA)
- Inpatient stay in a hospital or birthing center for the purpose of giving birth exceeding 48 hours following a normal vaginal delivery or 96 hours following a cesarean section;
- Gastric Bypass and stomach stapling;
- Home Infusion Therapy;
- Certain non-emergency ground ambulance services;
- Air-ambulance services for non-emergency hospital to hospital transfers;
- Hospice Care;
- Transgender services, including transgender travel expense, as specified under the Transgender Services provision. A doctor must diagnose you with Gender Identity Disorder or Gender Dysphoria.
- Cochlear implant.

Please note this list is not all inclusive, for a full list of current procedures requiring pre-certification, please call the toll-free number for Member Services printed on your identification card or visit: https://www.anthem.com/docs/public/inline/CA_PPO_PA_List.pdf.

Special Notes - this plan complies with the Newborns and Mothers Protection Act. The pre-certification requirement is not required to certify medical necessity for hospital or birthing center stays of 48 hours or less following a normal vaginal delivery, or 96 hours or less following a cesarean section.

Note that if a Covered Person receives certification for one facility, but then the person is transferred to another facility, certification is also needed before going to the new facility, except in the case of an emergency (see Special Note above).

Other Medical Management Services

Case Management Services are a planned approach aimed at promoting more effective treatment for patients with serious medical problems. Case Management Specialists communicate directly with the patient's attending physician to address the specific medical or psychological needs of the patient, and to mobilize appropriate resources for patient care. Our philosophy is that quality care from the beginning of a serious illness helps avoid major complications in the future. The Covered Person can request that the Plan provide case management services, or in some cases, the Plan may contact the Covered Person if the Plan believes case management services may be beneficial. The Case Management Specialists is staffed by physicians and other health care professionals and may be either the Third-Party Administrator's own utilization review team or an independent Third-Party, chosen at the sole and absolute discretion of the Plan Administrator.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- Prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- Approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.
You may purchase covered prescription drugs through the network in one of two ways:

- At a network retail pharmacy; or
- Through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.carelonrx.com

Coverage Categories and Your Copayment

There are three tiers in the prescription drug Plan; each has a different copayment that applies depending on where you have your prescription filled. Refer to the Summary of Medical Benefits chart(s) that shows your copayment amounts, copayment maximum out-of-pocket amounts.

Prescription Drug Tiers

Tier 1 – Generic Drug: Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug.

Tier 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. Most brand-name drugs used to treat asthma or diabetes are included in this category.

Tier 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available.

Dispense As Written

Prescription drugs will always be dispensed as ordered by your doctor. You may ask for, or your doctor may order, a brand name drug. However, if a generic drug is available, you will have to pay the difference in the cost between the generic and brand name drug. If a generic drug is not available, or if your doctor writes “Dispense as Written” or “Do Not Substitute” on your prescription, you will only have to pay the Copayment/Coinsurance applicable to the tier to which the brand drug is assigned. You will not be charged the difference in cost between the generic and brand name prescription drug. For certain higher cost generic drugs, we reserve the right, in our sole discretion, to make an exception and not require you to pay the difference in cost between the generic and brand name drug. By law, generic and brand name drugs must meet the same standards for safety, strength and effectiveness. Using generics generally saves money, yet gives the same quality.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. You will receive a prescription drug identification (ID) card from the Claims Administrator. Present this card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

If you choose to go to a pharmacy that is not in the CarelonRx network, you must pay for the prescription in full and file a claim with CarelonRx for reimbursement. CarelonRx will reimburse the billed charges minus your applicable Co-Pay.

NOTE: Specialty Medications are only covered when purchased through the CarelonRx’ specialty pharmacy BioPlus®

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. Non-formulary drugs are not eligible to be filled through the mail service program.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can also be refilled by phone or by using Pharmacy Manager’s Web site www.carelonrx.com

Voluntary Retail 90

Voluntary Retail 90 is a feature of your prescription benefit, managed by CarelonRx®. With it, you have two ways to get up to a 90-day supply of your long-term maintenance medication (those drugs you take regularly for ongoing conditions). You can conveniently fill those prescriptions either through home delivery from the CarelonRx Pharmacy℠ or at any participating in-network retail pharmacy. A 3-month supply at retail will mirror your Home Delivery CarelonRx Copays. You can also continue to fill a one-month supply of any medication at any in-network retail pharmacy without penalty. To locate one, log into anthem.com/ca or the Sydney app. Click on the Prescriptions home page and "Find a Pharmacy".

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Claims Administrator. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Claims Administrator with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist need to contact your doctor, who must then contact the Claims Administrator.

If your prescription is authorized by the Plan, you will be able to fill your prescription at any participating pharmacy or through the mail-service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period or lifetime, as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact the Claims Administrator.

Specialty Medications

Certain drugs are considered "specialty medications" and may only be purchased through a network pharmacy, except as required in an emergency. Specialty Medications must be obtained through CarelonRx' specialty pharmacy BioPlus®.

The following are the therapeutic classifications of specialty medications under the Plan:

- Blood Modifiers
- Hemophilia
- Interferon
- Pulmonary Hypertension
- Growth Hormones
- IGIV
- Oral Oncologics
- Other (as determined by the Plan)

For information on ordering specialty medications, dispensing limitations, and your required copayment for these drugs, contact the Prescription Drug Benefit Claims Manager.

Drug Cost Share Assistance Programs (CostRelief)

Drug Cost Share Assistance Programs - If you qualify for certain non-needs based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the Deductible, Copayment, or Coinsurance you pay for certain Specialty Drugs, the reduced amount you pay may be the amount we apply to your Deductible and/or Out-of-Pocket Limit. In addition, we may also enroll you in a program, the CarelonRx Cost Relief Program, which allows you to further reduce your costs, and may eliminate your out-of-pocket costs altogether. We will work with manufacturers to get the maximum cost share assistance you are eligible for and will manage enrollment and renewals on your behalf.

Participation in this program is voluntary. If you currently take one or more Prescription Drugs included in this program, we will automatically enroll you in the program and send you a welcome letter, followed up with a phone call that provides specific information about the program as it pertains to your medication. Whether you enroll in the Cost Relief Program or not, any non-needs-based cost-share assistance you receive will not accumulate to your {Deductible} {or} {Out-of-Pocket Limit}.

If you or a covered family member are not currently taking but will start a new Prescription Drug covered under this program, you can either contact us at 866-280-4120 or we will proactively contact you so that you can take full advantage of the program. Some drug manufacturers will require you to sign up to take advantage of the assistance that they provide. In those cases, we will contact you to let you know what you need to do. The list of Prescription Drugs covered by the CarelonRx Cost Relief Program may be updated periodically by the Plan. Please refer to our website, www.anthem.com, for the latest list.

Opting Out: If you do not wish to participate in this program, you can opt out, and you will be responsible for a portion of the cost of the Specialty Drug. Your cost will depend on the Specialty Drug prescribed and the level of cost share assistance that would have been available to you under the Cost Relief Program but will not be more than 50% of the Maximum Allowable Amount. Because certain Specialty Drugs are not classified as “essential health benefits” under the Plan in accordance with the Affordable Care Act, any Manufacture Assistance applied for these Specialty Drugs, do not count towards the Plan’s Deductible or Out-of-Pocket Limit. If you have already met your Deductible or Out-of-Pocket Limit with other claims, you will still be required to pay a portion of the cost for these Specialty Drugs. A list of Specialty Drugs that are not considered to be “essential health benefits” is available. An exception process is available for determining whether a Specialty Drug that is not an essential health benefit is medically necessary for a particular individual.

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- Alcohol swabs, when needed for injectable medicines;
- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Diabetic supplies (such as Chemstrips);
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Adapalene (Differin);
- Pigmenting and depigmenting agents;

- Drugs to treat narcolepsy including Provigil;
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin);
- Vitamins and dietary supplements that require a prescription;
- Fertility drugs;
- Oral contraceptives, injectable contraceptives, and contraceptive devices (e.g., IUDs and diaphragms);
- All dosage forms of smoking-cessation aids, whether prescription type (such as Wellbutrin), or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- AZT, Retrovir, and other drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.

Prescription Drug Expenses Not Covered

The following drugs and supplies, among others, are not covered under the Plan:

- Allergy desensitization products or allergy serum;
- Any prescription refilled in excess of the number specified by the doctor, or any refill dispensed more than one year after the doctor's original order;
- Any drug or medication prescribed for experimental indications including, but not limited to, drugs labeled "Caution—limited by Federal law to investigational use";
- A non-prescription patent or proprietary medicine or medication not requiring a prescription, except insulin;
- Anorexiants (diet pills, appetite suppressants, etc);
- Drugs or supplies covered under Workers' Compensation or occupational disease law or any similar law;
- Drugs and medications dispensed by or administered in an outpatient setting, including, but not limited to, outpatient hospital facilities and physician's offices;
- Drugs and medications dispensed by or while the member is confined in a hospital or skilled nursing facility, rest home, sanitarium, convalescent hospital or similar facility;
- Drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Drugs used primarily for the purpose of treating infertility;
- Durable medical equipment, devices, appliances and supplies, even if prescribed by a physician (refer to medical plan benefits);
- Hypodermic syringes and/or needles, except when dispensed for use with insulin;
- Immunizing agents, biological sera, blood products or blood plasma;
- Prescriptions filled in hospital out-of-network pharmacies at time of discharge;
- Professional charges in connection with administering, injecting, or dispensing of drugs;
- Retin-A over age 30 unless obtain a prior authorization;
- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- Drugs used to treat or cure baldness or hair loss (e.g., Minoxidil);

- Drugs for weight loss;
- Immunization agents or biological sera;
- Anti-Wrinkling Agents (e.g., Renova);
- All Over-the-counter drugs and products;
- Drugs used for treatments that are cosmetic-related;
- Injectable supplies (other than for insulin).

For More Information - If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Pharmacy Help Line at the number listed on the back of your ID card.

CREDITABLE COVERAGE NOTICE
IMPORTANT INFORMATION FROM LUMINARE HEALTH BENEFITS, INC.
ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Employer and prescription drug coverage with Anaheim Union High School District. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescriptions drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Luminare Health Benefits, Inc. has determined that the prescription drug coverage offered by your Employer is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Employer's prescription drug coverage, be aware that you and your Dependents may not be able to get this coverage back. Please contact Luminare Health Benefits, Inc. for more information on what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose coverage with your Employer and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month every month that you did not have that coverage. For example, if you go nineteen (19) months without coverage, your premium will always be at least 19% higher than what other people may pay. You'll have to pay this higher premium as long as you have Medicare Prescription drug coverage. In addition, you may have to wait until the following November to enroll.

Your current prescription drug coverage.

To review your current prescription drug plan provisions, please refer to the prescription portion of this Summary Plan Document (see this section) or contact Customer Service on the back of your ID Card.

For more information about this notice.

Contact customer service at 866-730-8586 for further information. **NOTE:** You will receive this notice annually and at other times in the future such as before your next period you can enroll in Medicare prescription drug coverage, if coverage through your Employer changes, or you may request a copy.

For more information about your options under Medicare prescription drug coverage.

More detailed information about Medicare plans that are offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-468-2048.

For people with limited income and resources, extra help paying for Medicare drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov or you can call them at 1-800-722-1213 (TTY 1-800-328-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty).

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- How to contact the Plan Administrator;
- How to contact the Claims Administrators;
- What to do if a benefit claim is denied; and
- Your rights under Federal laws such as COBRA.

Plan Sponsor and Administrator

Anaheim Union High School District is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Anaheim Union High School District
501 N. Crescent Way
Anaheim, CA 92801
(714) 999-3511

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if Plan Administration duties are delegated to an individual who is an Employee of the District. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible Employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible Employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the District, eligible Employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the Plan Administrator.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator has the sole discretion to interpret Plan provisions, and such decisions are conclusive and binding.

Plan Name

Anaheim Union High School District Health Benefit Plan

Plan Year

The Plan Year is January 1 through December 31.

Name and Address of Employer

Anaheim Union High School District
501 N. Crescent Way
Anaheim, CA 92801

Plan Status

Non-grandfathered.

Type of Plan

Self-funded Health & Welfare Plan providing medical and prescription drug benefits

Employer Identification Number

The Employer Identification Number (EIN) is:

- EIN: 95-6000120

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The District and Employees both contribute to the Plan. The District will use these contributions to pay benefits to or on behalf of Plan participants from the District's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using District contributions to pay for the cost of such benefit.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Collective Bargaining Provisions

The plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreements may be obtained upon written request to the Plan Administrator, and such agreements are available for examination.

Compliance

It is intended that this Plan comply with all applicable laws, including, but not limited to, the Consolidated Appropriations Act of 2021, GINA, and the Mental Health Parity and Additional Equity Act of 2008. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Medical

Claims Administrator (Covered Person)

Luminare Health Benefits, Inc.
P.O. Box 2920
Clinton, IA 52733-2920
(866)280-4120
www.luminarehealth.com

Network / Claims Administrator (Provider)

Anthem Blue Cross
Prudent Buyer Plan - PPO
P.O. Box 60007
Los Angeles, CA 90060-0007
(800) 688-3828

Prescription Drug Benefit Claims Manager

CarelonRx
Customer Service:
www.carelonrx.com (877)
638-4008

Agent for Service of Legal Process

Anaheim Union High School District
Risk Management
501 N. Crescent
Way
Anaheim, CA 92801
(714) 999-3511

Service of legal process can also be made upon the Plan Administrator.

Not a Contract

This Summary Plan Document is not to be construed as a contract of any type between the District and any participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Summary Plan Document shall be deemed to give any Employee the right to be retained in the service of the District or to interfere with the right of the District to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the District with the bargaining representatives of any Employees.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN), your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has the authority to determine whether an order qualifies as a QMCSO or NMCSO.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the Covered Participant, unless otherwise assigned.

Proof of Loss

Covered Persons are responsible for ensuring that complete claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than 18 months from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the District.

Fraud

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. These actions, as well as submission of false information, will result in denial of the Covered Person’s claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

Rescission due to Fraud or Misrepresentation

The Plan Administrator will rescind the benefits and/or coverage under this Plan, upon 30 days written notice to the Covered Person, for any material misrepresentation or intentional fraud committed by the Covered Person and relied upon to the detriment of the Plan Administrator in providing coverage and/or benefits under the Plan. In no other circumstances will rescission of benefits and/or coverage occur.

Covered Persons must:

- File accurate claims. If someone else – such as your spouse/domestic partner or another family member – files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan Identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claims forms and any other forms. Answer all questions to the best of your knowledge.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect illegal activity, should call the toll-free hotline 866-727-5892. All calls are strictly confidential.

Conformity with Applicable Laws

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement.

Amending and Terminating the Plan

The Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor. Benefits for claims incurred after effective date of amendment will be paid according to the revised Plan provisions. In other words, once the

Plan is amended, there are no rights to benefits based on earlier Plan provisions

If the Plan is terminated, the rights of the Plan participants are limited to expenses incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for covered expenses incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered participants.

Summary of Material Modification (SMM)

NOTE: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average Participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or co-payments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60- day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered participant of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 30 days from the date written notice is given.

Headings/Footers

The headings/footers used in this SPD are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading/footer.

No Waiver or Estoppel

All parts, portions, provisions, conditions and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein and shall be interpreted in the most narrow fashion possible.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the participating Employer and the amount to be contributed (if any) by each participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Administrator's obligation with respect to such payments.

In the event that the Plan Administrator terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims incurred after the termination date of the Plan.

Written Notice

Any written notice required under this Plan which, as of the effective date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements

All statements made by the District or Plan Administrator or by a participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document, unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The participant may be subject to prosecution by applicable government agencies. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any participant, the Plan Administrator in its sole discretion may terminate the interest of such participant or former participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such participant or former participant, his or her spouse/domestic partner parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such participant or former participant, as the Plan Administrator may determine. Any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including

any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

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

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

The arbitration is begun by the participant making written demand on the Plan Administrator. The arbitration will be conducted by a neutral arbitration entity, by mutual agreement of the participant and the Plan Administrator, or by order of the court, if the participant and the Plan Administrator cannot agree.

The costs of the arbitration will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Claims Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a participant subsequently requests payment with respect to the voided check, the Claims Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable State law(s).

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims - generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims - if you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact the Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, the Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

All out-of-network claims—submitted by either you or by the provider or facility—must be submitted to the Plan within 18 months after the date of service. Claims submitted after that deadline will not be paid.

Time-Frames for Processing a Claim

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Claims Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Claims Administrator.

The chart on the following page shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time-Frames for Processing a Claim			
Claim Process	**Urgent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:			
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information	Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim	Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period, ** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. An adverse benefit determination also involves consideration of whether the Plan is complying with the Surprise Billing restrictions of the No Surprises Act (refer to Plan Provisions – Balance Billing). It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in a plan.

If a claim is being denied in whole or in part, the Covered Person will receive an initial claim denial notice with the timelines described above. A claim denial notice, usually referred to as an Explanation of Benefit (EOB) form will:

- Explain the specific reason for the denial;
- Provide a specific reference to pertinent Plan provisions on which the denial was based;
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable;
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

How to Appeal a Claim

To appeal a denied claim or to request administrative documents pertinent to the claim, you or your Authorized Representative must send a written request to the Claims Administrator. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your Authorized Representative submits an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time-Frames for Appealing Denied Claim			
Appeal Process	**Urgent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Claims Administrator	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Claims Administrator reviews your second appeal and makes final determination	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the decision in writing. If your claim is denied, you will be provided, in writing, the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the time- frames permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

You will be notified of the Plan Administrator’s decision in writing. If your claim is denied, which is called an adverse benefit determination, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

If you receive notice of a final internal adverse benefit determination, or if the Plan does not follow the claims procedures properly, the participant then has the right to request an independent external review. The external review procedures are described below.

External Review Rights/Independent Review Organization (“IRO”)

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor (“DOL”) regulation, 29 CFR § 2560.503-1, Public Health Service (“PHS”) Act § 2719. Where any provision is in conflict with the DOL's claims procedure regulations, or any other applicable law, such law shall control.

If your final appeal for a claim is denied, you will be notified in writing that your claim is eligible for an external review and you will be informed of the time-frames and the steps necessary to request an external review. You must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator, and the Plan.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

Appointment of Authorized Representative

A participant may designate another individual to be an Authorized Representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the participant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a participant’s treating health care practitioner to act as the Participant’s authorized representative without completion of the authorized representative form.

Should a participant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the participant, unless the Plan Administrator is otherwise notified in writing by the participant. A participant can revoke the authorized representative at any time. A participant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a participant shall not be recognized as a designation of the provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Physical Examinations

Should there be, in the Plan Administrator's discretion, any question as to the participant's health or physical condition, such that the medical necessity of care sought by the participant is called into question, the Plan may, at its own expense, have a physician of its choice perform a physical examination, as necessary to confirm medical necessity. Should the participant refuse to comply with said exam, the care may be deemed to be excluded by the Plan, at the Plan Administrator's discretion.

Autopsy

Upon receipt of a claim for a deceased participant for any condition, sickness, or if injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Participant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Participant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Participant be deceased, payment shall be made to the Participant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Assignments

Assignment by a participant to the provider of the participant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an assignment of benefits, if and only if the provider accepts said assignment of benefits as consideration in full for services rendered. If benefits are paid, however, directly to the participant, despite there being an assignment of benefits the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the participant's responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an assignment of benefits is valid; and the participant shall retain final authority to revoke such assignment of benefits if a provider subsequently demonstrates intent not to accept it as payment in full for services rendered.

As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the participant, has been received. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the Participant and shall not constitute an assignment of rights under the Plan.

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

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

Benefits due to any in-network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Non U.S. Providers

A provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States, shall be deemed to be a “Non U.S. Provider.” Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the participant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the participant be made. If payment was made by the participant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the participant shall be that amount. If payment was made by the participant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to,

and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

Recovery of Payments

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

A participant, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan

Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

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

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

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

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

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's Subrogation and Reimbursement provisions;
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

Medicaid Coverage

A participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Coordination of Benefits

NOTE: THE EPO Plan does not coordinate benefits with any other medical plan, whether dual coverage under another AUHSD Employee plan or external coverage through another Employer. The EPO Plan will never make a payment as secondary payor; any claims submitted for reimbursement for which a member has primary coverage will be denied.

The below applies to Covered Persons enrolled in the PPO plan only.

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. It does not however, apply to prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determines which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges incurred may be paid between both plans.

This Plan will not cover any benefit reduction by the primary plan because a covered person has failed to first comply with the primary plan's provisions. Examples of these type of plan provisions include; second surgical opinions, pre-certification or prior authorization of admissions, and preferred provider arrangements.

Dual Choice

When a husband and wife or State registered domestic partner are both enrolled as Employees under this Plan, each has the option to enroll eligible Dependents for coverage hereunder. The combined maximum contractual benefits, to which both Employees and Dependents are entitled, shall not exceed 100% of the Covered Expenses. Calendar year Deductibles and prescription drug Co-pays do not apply.

Order of Benefit Determination Rules

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary;
- If you are the Employee, this Plan normally is primary when you have a covered expense;
- If you are the subscriber on an Early Retiree plan, this Plan is normally primary when you have a covered expense;

- If your covered spouse/domestic partner is the patient, your spouse's/domestic partner's company plan (if applicable) is primary. Your spouse/domestic partner should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB);
- When both parents' plans cover an eligible Dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's/domestic partner's birthday is March 15 and your birthday is September 28, your spouse's/domestic partner's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits;
- When parents who were never married, are legally separated, or are divorced and both cover an eligible Dependent child, the following rules apply.
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply;
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan);
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary;
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary;
    - When none of the previous rules applies, the plan that has covered the child for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group Employer. Generally, for large group Employer plans, Medicare requires the Employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

Order of Benefit Determination Rules for Medicare

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally has primary responsibility to pay claims before Medicare under the following circumstances:
  - You continue to be actively employed by the Employer and you or your covered spouse becomes eligible for and enrolls in Medicare because of age or disability;
  - You continue to be actively employed by the Employer; your covered spouse becomes eligible for and enrolls in Medicare and is also covered under a Retiree plan through your spouse's former Employer. In this case, this Plan will be primary for you and your covered spouse, Medicare pays second, and the Retiree plan would pay last;
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer;
- Medicare generally pays first (has primary responsibility) under the following circumstances:
  - You are no longer actively employed by an Employer; and
  - You or your spouse has Medicare coverage due to your age, plus you also have COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus you also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with End-Stage Renal Disease until the end of the 30-month period; or
  - You or your covered spouse have coverage under a Retiree plan plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered Dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- Any deductible under the automobile coverage;
- Any copayment under the automobile coverage;
- Any expense properly denied by the automobile coverage that is a covered expense; and
- Any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

SUBROGATION AND REIMBURSEMENT

Payment Condition

- The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “participant(s)”) or a Third-Party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, Third-Party assets, Third-Party insurance, and/or guarantor(s) of a Third-Party (collectively “Coverage”).
- Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and Third-Party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.
- In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.
- If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the Plan may seek reimbursement.

Subrogation

- As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.
- If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
- The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
- If the Participant(s) fails to file a claim or pursue damages against:
    - The responsible party, its insurer, or any other source on behalf of that party;
    - Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    - Any policy of insurance from any insurance company or guarantor of a Third-Party;
    - Workers' compensation or other liability insurance company;
    - Any other source, including but not limited to crime victim restitution funds; any medical, disability or other benefit payments, and school insurance coverage.

  The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

- The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorney's fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. 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 interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
- No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
- The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the participant(s).
- This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Participant is a Trustee Over Plan Assets

- Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which

may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

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

- To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control; in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
- No participant, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a Third-Party;
- Workers' compensation or other liability insurance company;
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the participant(s), such that the death of the participant(s), or filing of bankruptcy by the participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a Third-Party or any coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the participant(s) and all others that benefit from such payment.

Obligations

It is the participant's/participants' obligation at all times, both prior to and after payment of medical benefits by the Plan: To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

- To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
- To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
- To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or coverage;
- To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
- In circumstances where the participant is not represented by an attorney, instruct the insurance company or any Third-Party from whom the participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft;
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and participant over settlement funds is resolved.

If the participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the participant(s);

The Plan's rights to reimbursement and/or subrogation are in no way Dependent upon the participant's/participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the participant(s) in an amount equivalent to any outstanding amounts owed by the participant to the Plan. This provision applies even if the participant has disbursed settlement funds.

Minor Status

- In the event the participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
- If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe 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 may amend the Plan at any time without notice.

Receive Information about Your Plan and Benefits

You may:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and updated Summary Plan Description. The Plan Administrator may require a reasonable

charge for the copies.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling (714) 999-3511.

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual's physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called "ePHI."

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. "Summary Health Information" means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered Dependent(s) may continue health care coverage at your or your Dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible Dependent(s) choose COBRA coverage, the District is required to offer the same medical and prescription drug coverage that is offered to similarly situated Employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered Dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health

benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible Dependent(s) may continue for 18 months after the date of the qualifying event if your:

- Employment ends for any reason other than gross misconduct; or
- Hours of employment are reduced.

Social Security Disability Determination (For Employees and Dependents)
18-Month Continuation Plus 11-Month Extension

If you or your eligible Dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- He or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- He or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- He or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your Dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible Dependent(s) may continue for up to 36 months if coverage is lost due to your:

- Death;
- Divorce or legal separation;
- Eligibility for Medicare coverage; or
- Dependent child's loss of eligible Dependent status under this Plan

NOTE: If any of these events (other than Medicare entitlement) occur while your Dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your Dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA NOTICE PROCEDURES

The Notice(s) a Covered Person must provide under this Summary Plan Document

To be eligible to received COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either your Employer or the COBRA administrator.

A Qualified Beneficiary's written notice must include all of the following information:

- The Employee and Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the Employer that the Employee was with,
- Description of the Qualifying Event (i.e. the Life Event experienced), and
- The date that the Qualifying Event occurred or will occur.

Send all notices or other information required to be provided by this Summary Plan Document in writing to:

Luminare Health Benefits, Inc.
P.O. Box 2920
Clinton, IA 52733-2920
(866)280-4120
www.luminarehealth.com

For purposes of the deadlines described in this Summary Plan Document, the notice must be postmarked by the deadline. In order to protect your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

Employer Obligation to provide Notice of the Qualifying Event

Your Employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both). Your Employer has 44 calendar days from the later of the date of the Qualifying Event or the date of the loss of coverage to send the notice.

Employee Obligation to provide Notice of the Qualifying Event

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Document or General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the Employer, covered Employee or the Qualified Beneficiary.

Making an Election to Continue Group Health Coverage

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election from that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments with when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end the last day of the month following the Qualifying Event. (Except if the Qualifying Event is the death of an AFSCME or CSEA Employee, then coverage for Dependents will end the last day of the month following 4 months of the date of death.)

A Qualified Beneficiary's Notice Obligations While On COBRA

Always keep the COBRA Administrator informed of the current address of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause you or your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date a Child is born, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date of final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan.
- Additionally, if the COBRA Administrator or the Plan Administrator request additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

Cost of COBRA Coverage

You or your eligible Dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your Dependent is responsible for making timely payments.

If you or your Dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments is as follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for State or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your State Insurance Commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" and "Your Dependent's Coverage (Applies to Active and COBRA" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- At the end of the leave if you do not return after the leave; or
- On the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election);
- The maximum period of COBRA coverage, as it applies to the qualifying event,

expires;

- The last day of the month in which individual becomes covered under any other group medical plan;
- The individual becomes entitled to Medicare;
- The District terminates its group health plan coverage for all Employees;
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Early Termination of COBRA Continuation

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The Employer ceases to maintain a group health plan for any Employees. (Note that if the Employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and cost may not be the same.)
- The required contribution for the Qualified Beneficiary's coverage is not paid on time.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

COBRA DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) immediately before the Qualifying Event.

Qualifying Event means the Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employees cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

Introduction

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an Employer has different types of benefits available depending on the type of leave of absence, the most favorable benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Waiting Periods.

Coverage

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leaves begins, or
- A period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA Notice and Election

An Employee or an appropriate office of the uniformed service in which his or her service is to be performed must notify the Employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible to unreasonable under all of the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Unlike COBRA, Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

Payment

If the military orders are for a period of 30 days or less, the Employee is not required to pay more than amount he or she would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

Extended Coverage Runs Concurrent

Employees and their Dependents may be eligible for COBRA and USERRA at the same time. Election of either COBRA or USERRA extension by an Employee on leave for military services will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- Is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- Was present at work on the last scheduled working day before:
    - A scheduled vacation;
    - An absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - A scheduled day off within the participant's working schedule; or
    - An absence excused by the company.

Adverse Benefit Determination

Means any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage, even if the rescission does not impact a current claim for benefits;
- A termination of benefits;
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the Plan;
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Affordable Care Act (ACA)

The health care reform law enacted in March 2010 was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name Affordable Care Act is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Allowable Expenses

The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's allowable expenses shall in no event exceed the other plan's allowable expenses.

When some "other plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Approved Clinical Trial

A Phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "approved clinical trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself;

2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out of network benefits are otherwise provided under the Plan.

Birthing Center

A facility that provides prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

California Family Rights Act

The California Family Rights Act (CFRA) is a California law that provides for an unpaid, job-protected leave of absence for up to 12 weeks per year. It also requires that group health benefits be maintained during the leave. CFRA applies to any of the following reasons:

- The birth or adoption of a child, or placement of a foster child in a participant's home;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- The care of a child, parent, parent-in-law, grandparent, sibling, spouse, or domestic partner, as defined by state law, who has a serious health condition;
- A participant's own serious health condition; or
- For qualifying exigencies related to the foreign deployment of a military member who is the Employee's spouse, child, or parent

Generally, you are eligible to take a qualifying leave under CFRA if you have worked for the District for at least 12 months; you have worked at least 1,250 hours during the previous 12 months; and you continue to pay any required premium during your leave as determined by the District. You should contact the District with any questions you have regarding eligibility for CFRA leave or how it applies to you.

Time taken off work due to pregnancy complications is not counted against the 12 weeks of CFRA family and medical leave.

Centers of Excellence

Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the procedures performed by these Centers include heart, lung, liver, pancreas, kidney, and bone marrow transplants.

Certified Nurse-Midwife

A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID, and provide services in line with nurse-midwife certification.

Chiropractic Care

Services provided by a Chiropractor (D.C.) or licensed physician (M.D. Or D.O.) including office visits, diagnostic X-rays, manipulations, supplies, heat treatment, cold treatment and massages.

Claims Administrator

The Claims Administrator processes claims for your Employee benefit plan.

Clean Claim

A claim that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a Third-Party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A clean claim does not include claims under investigation for fraud and abuse or claims under review for medical necessity and reasonableness, or fees under review for usual and customary, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

A provider submits a clean claim by providing the required data elements on the standard claim forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The

Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal), to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a clean claim if the Participant has failed to submit required forms or additional information to the Plan as well.

Close Relative

A member of the immediate family; immediate family includes you, your spouse, your State registered domestic partner, mother, father, grandmother, grandfather, stepparents, step grandparents, siblings, stepsiblings, half siblings, children, your State registered domestic partner’s children.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Covered Expense(s)

A usual and customary fee for a reasonable, medically necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage under this Plan. Covered expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the covered expense is the least costly option that is no less effective than any other option.

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

Custodial Care

Services and/or care not intended primarily to treat a specific injury or illness (including mental health and substance abuse). Services and care include, but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible

The dollar amount (for individual or family) a participant must pay each calendar year before the Plan begins to pay benefits.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor/Physician

A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term also includes a Chiropractor (D.C.), Dentist (D.M.D. or D.D.S.), or a Podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Durable Medical Equipment

Equipment such as braces, crutches, hospital beds, etc. that is primarily and customarily used to serve a medical purpose that:

- Can stand repeated use;
- Generally, is not useful to a person in the absence of an illness or injury;
- Is appropriate for use in the home.

Emergency

A situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (1) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. An emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so 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 (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services

With respect to an emergency medical condition, emergency services mean the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee

A person who works for the District in an Employer-Employee relationship.

Essential Health Benefits

As defined under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use; or
- Not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Plan Administrator retains maximum legal authority and discretion to determine what is experimental or investigational.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid, job-protected leave of absence for up to 12 weeks per year. It also requires that group health benefits be maintained during the leave. FMLA applies to any of the following reasons:

- The birth or adoption of a child, or placement of a foster child in a participant's home;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- The care of an immediate family member (child, spouse or parent, not including parents-in-law), as defined by Federal law, who has a serious health condition;
- A participant's own serious health condition; or
- For qualifying exigencies related to the foreign deployment of a military member who is the Employee's spouse, child, or parent

An eligible Employee who is a covered service member's spouse, child, parent or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

Generally, you are eligible to take a qualifying leave under FMLA if you have worked for the District for at least 12 months; you have worked at least 1,250 hours during the previous 12 months; your District has at least 50 Employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the District. You should contact the District with any questions you have regarding eligibility for FMLA leave or how it applies to you.

Time taken off work due to pregnancy complications can be counted against the 12 weeks of FMLA family and medical leave.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Generic Drug Alternative

A generic drug that is not the exact equivalent of the brand-name drug but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent

A generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand-name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

Genetic Information

Genetic information includes information about genes, gene products, and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status or information derived from laboratory tests that identify mutations in specific genes or chromosomes, medical examinations, family histories, or direct analysis of genes or chromosomes.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

Habilitation

A type of treatment that seeks to help patients improve or develop skills or functions they are incapable of developing on their own

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Home Health Care

A formal program of care an intermittent treatment that is: Performed in the home; and prescribed by a Physician; an intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For the purposes of Home Health Care, Nurse Services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care i.e. care that is not provided on a continuous, non-interrupted basis.

Hospice

A licensed (if required by the State in which it is located) facility set up to give terminally ill patients a coordinated program of inpatient, outpatient, and home care. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing. The Plan must approve the hospice and treatment plan supervised by a physician.

Hospice Care Provider

An agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and if required, is licensed as such by jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling services of a Physician, physical or occupational therapist; home health aide services; pharmacy services and Durable Medical Equipment.

Hospital

A legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
    - General inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
    - Specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital that itself qualifies under the above description, or with a specialized provider of these facilities.

For purposes of this plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. The term hospital does not include a facility that primarily is a place for rest, a place for the aged, residential treatment centers, or a nursing home.

Illness (or Disease)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory finding peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Improper Claim

A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time-frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Incurred

A covered expense is “incurred” on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Contractor

An entity or individual who performs services to or on behalf of the Employer who is not an Employee or an officer of the Employer and who retains control over how the work gets done. The Employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determine as to whether an individual or an entity is an Independent Contractor shall be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment

Service, tests supplies, devices or drugs, which are intended to promote fertility, achieve a condition of pregnancy, or treat an illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility test and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs or semen.

Injury

An accidental bodily injury that is the sole and direct result of an accident or a reasonably unforeseeable consequence of a voluntary act by the person.

Inpatient

A registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

In-Network Provider

A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Learning Disability

A group of disorders that result in significant difficulties in one or more of seven areas including; basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the Individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Leased Employee

Leased Employee as defined in the Internal Revenue Code, section 414(n), as amended.

Legal Guardianship

The individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed at least one of the following:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The reasonable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a provider;
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a medically necessary and reasonable service.

The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Condition

A condition for which the individual has sought and received medical treatment.

Medically Necessary

To be medically necessary, all care must be:

- In accordance with standards of good medical practice;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;
- Required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- Provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- Consistent with the eligible diagnosis of the condition;
- Not experimental or investigational, as determined by the Plan; and
- Demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically necessary for the proper treatment of the participant and may also require the participant to be independently examined while a claim is pending. The Plan Administrator has the discretionary authority to decide whether care or treatment is medically necessary.

Medical Record Review

The process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the maximum allowable charge according to the medical record review and audit results.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Disorder

Disorders that are clinically significant psychological syndromes associated with distress, dysfunction or illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to increased risk of pain, suffering, conflict, Illness or death.

Mentally Disabled
An individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Morbid Obesity

A Covered Person who weighs more than 100 pounds over standard weight for height, sex and age; or a Covered Person who weighs more than two times the standard weight for height, sex and age; or for a Covered Person who is less than 19 years of age where the Body Mass Index falls above the 95th percentile on the growth chart.

Multiple Surgical Procedures
When more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate
The amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

NMHPA

The Newborn's and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Orthognathic Condition

A skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, under bite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances

Braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally, is not useful to a person in the absence of an Illness or Injury.

Other Plan

Includes, but is not limited to:

- Any primary payer besides the Plan;
- Any other group health plan;
- Any other coverage or policy covering the Participant;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a responsible party;
- Any policy of insurance from any insurance company or guarantor of a Third-Party.
- Workers' compensation or other liability insurance company;
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered Dependents) in a calendar year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Outpatient

Medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care

The cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone or both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized illness, Injury, or symptoms involving the foot.

Participant or Covered Person

An eligible Employee or Dependent who elects to participate in the Plan by completing the necessary enrollment forms.

Physician

Any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan; a doctor of medicine (MD), doctor of dental medicine including Oral Surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), physician's assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or Placement for Adoption

The assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan

Anaheim Union High School District Group Health Benefit Plan.

Plan Administrator / Plan Sponsor

The Plan Administrator / Plan Sponsor sponsors and has discretionary authority with respect to the health Plan**.**

Post-Service Health Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (See "Affordable Care Act").

Pregnancy Disability Leave

The Pregnancy Disability Leave Law (PDL) is a California law that provides for an unpaid, job-protected leave of absence for up to four months (the working days you normally would work in one-third of a year or 17 1/3 weeks). It also requires that group health benefits be maintained during the leave. CFRA applies for the period of time that you are disabled by pregnancy, childbirth, or related medical condition. Your health care provider determines how much time you will need. You must continue to pay any required premium during your leave as determined by the District. You should contact the District with any questions you have regarding eligibility for PDL leave or how it applies to you.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Prescription Drug Benefit Claims Manager

The Prescription Drug Benefit Claims Manager processes and pays prescription drug claims

Preventive Care

Certain preventive care services.

This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for all of the following:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:

http://www.uspreventiveservicestaskforce.org or at

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

For more information, you may contact the Plan Administrator / Employer.

Provider

An entity whose primary responsibility is related to the supply of medical care. Each provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "provider" as defined herein if that entity is not deemed to be a "provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified
Licensed, registered or certified by the state in which the provider resides.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: (1) provides for child support with respect to the Employee's child or directs the Employee to provide coverage under a health benefit plan under a State domestic relations law, or (2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under State law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Reasonable
"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of illness or injury not caused by the treating provider's error or mistake.

Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (1) The National Medical Associations, Societies, and organizations; (2) The Centers for Medicare and Medicaid Services (CMS) and (3) The Food and Drug Administration. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

To be reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the Plan Administrator.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Reconstructive Surgery
Surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists, and the surgery restores or improves function.

State Registered Domestic Partner
A State registered domestic partner is a person who has filed a Declaration of Domestic Partnership with the State government and has received a legal conformed copy of that declaration.

Retired Employee (Retiree)
A person who was employed full time by the Employer who is no longer regularly at work and who is now retired under the Employer's formal retirement program.

Skilled Nursing Facility
A facility that qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and is approved by the Plan

Summary Plan Document
A document containing a comprehensive description of a Plan, including the terms and conditions of participation.

Surgical Center
A licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional wellbeing of patients;
- Provides Emergency Services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine
The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications.

Temporomandibular Joint Disorder (TMJ)
A disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill
A life expectancy of about six months.

Third-Party Administrator (TPA)
A service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled

An Employee who is determined as disabled for Social Security purposes.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed service leave.

Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Usual and Customary

"Usual and Customary" (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan

Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered Dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The Anaheim Union High School District Health Benefit Plan Summary, as stated herein, is hereby adopted as of 01/01/2025. This document constitutes the basis for administration of the Plan.

IN WITNESS WHERE OF, the parties have caused this document to be executed on this 26 day of September, 2025.

BY: _____

TITLE: Assistant Superintendent, Business Services